AMENDED IN ASSEMBLY SEPTEMBER 1, 2015

SENATE BILL No. 804

Introduced by Committee on Health (Senators Hernandez (Chair), Hall, Mitchell, Monning, Nguyen, Nielsen, Pan, Roth, and Wolk)

March 26, 2015

An act to amend Sections *1366.22,* 11801, *11811.6,* 11830.1, 11835, *24100,* 103577, 104151, ~~and 128456~~ *128456, 130302, and 130304* of, *to amend, repeal, and add Sections 1366.24 and 1366.25 of,* and to repeal Sections 130316 and 130317 of, the Health and Safety Code, *to amend Section 10128.52 of, and to amend, repeal, and add Sections 10128.54 and 10128.55 of, the Insurance Code,* and to amend Sections *729.12,* 4033, 4040, 4095, 4096.5, *4117, 5121, 5150, 5152.1, 5152.2, 5250.1, 5305, 5306.5, 5307, 5308,* 5326.95, *5328, 5328.2, 5346,* 5400, 5585.22, 5601, 5611, 5664, *5694.7,* 5701.1, 5701.2, 5717, 5750, *5814.5,*5845, 5847, 5848, 5848.5, 5892, 5899, 5902, *6002.25, 8103,* 11467, 11469, 14021.4, 14124.24, 14251, 14499.71, *14682.1,* 14707, 14711, 14717, 14718, 14725, 15204.8, ~~15847.7, and 17604~~ *and 15847.7* of the Welfare and Institutions Code, relating to ~~health.~~ *public health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 804, as amended, Committee on Health. ~~Health.~~ *Public health.*

(1) The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. The California Continuation Benefits Replacement Act (Cal-COBRA) requires health care service plans and health insurers providing coverage under a group benefit plan to employers of 2 to 19 eligible employees to offer a continuation

of that coverage for a specified period of time to certain qualified beneficiaries, as specified. Existing law requires a group benefit plan that is subject to Cal-COBRA to make specified disclosures to covered employees, including that a covered employee who is considering declining continuation of coverage should be aware that companies selling individual health insurance may require a review of the employee's medical history that could result in a higher premium or denial of coverage.

This bill would eliminate the disclosure requirement described above. If federal law requiring an individual to maintain minimum health coverage is repealed or amended to no longer apply to the individual market, as specified, the bill would reenact that disclosure requirement to become operative 12 months after that repeal or amendment. The bill would also, under those same conditions, require a contract between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to make the same disclosure to a qualified beneficiary in connection with a notice regarding election of continuation coverage. The bill would require a group benefit plan that is subject to Cal-COBRA and that issues, amends, or renews a disclosure on or after July 1, 2016, to include a notice regarding additional health care coverage options in that disclosure, as specified. The bill would require a group contract that is issued, amended, or renewed on or after July 1, 2016, between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to give that notice regarding additional health care coverage options to a qualified beneficiary of the contract in connection with a notice regarding election of continuation coverage. The bill would make conforming changes to related provisions.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, this bill would impose a state-mandated local program.

~~(1)~~

(2) Existing law regulates provision of programs and services relating to mental health and alcohol and drug abuse at the state and local levels and serving various populations. These provisions contain various obsolete references to the California Mental Health Directors Association, the County Alcohol and Drug Program Administrators' Association of California, and similar entities.

This bill would delete those obsolete references and would refer instead to the County Behavioral Health Directors Association of

California, and would make additional conforming ~~changes.~~ *changes to certain provisions relating to mental health directors and alcohol and drug program administrators.*

~~(2)~~

(3) Existing law requires the State Department of Health Care Services to provide, no later than January 10 and concurrently with the May Revision of the annual budget, the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program for early detection of breast and cervical cancer.

This bill would require the department additionally to provide to the fiscal and appropriate policy committees of the Legislature quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program, as prescribed. The bill would declare the intent of the Legislature that these provisions supersede similar reporting requirements imposed on the State Department of Public Health by specified uncodified legislation.

~~(3)~~

(4) Existing law, for purposes of Medi-Cal provisions relating to entities that provide payment for certain covered services on behalf of eligible persons, ~~enrollees~~ *enrollees*, or subscribers, includes a nonprofit hospital service plan within the descriptions of a fiscal intermediary, a prepaid health plan, and group health coverage.

This bill would delete a nonprofit hospital service plan from inclusion as a fiscal intermediary, prepaid health plan, or group health coverage, under the above circumstances.

~~(4)~~

(5) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties as State Registrar relating to the uniform administration of provisions relating to vital records and health statistics. Existing law requires the State Registrar, local registrar, or county recorder to, upon request and payment of the required fee, supply to an applicant a certified copy of the record of a birth, fetal death, death, marriage, or marriage dissolution registered with the official. Existing law authorizes the issuance of certain records without payment of the fee.

Existing law, on and after July 1, 2015, requires each local registrar or county recorder to issue, without a fee, a certified record of live birth to any person who can verify his or her status as a homeless person or a homeless child or youth, as defined.

This bill would specify that no issuance or other related fee would be ~~changed~~ *charged* under the above circumstances.

~~(5)~~

(6) Under the Health Insurance Portability and Accountability Implementation Act of 2001, the Office of HIPAA Implementation assumes statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation, and exercises full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on implementation efforts. Under existing law, these duties have been assumed by a successor entity, the Office of Health Information Integrity. These provisions become inoperative and are repealed as of June 30, 2016, at which time funds appropriated for purposes of the act that remain unexpended and unencumbered, revert to the General Fund.

This bill would indefinitely extend the act and the operation of the office by deleting the June 30, 2016 repeal date. *The bill would update references to the office to refer instead to the Office of Health Information Integrity.*

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 1366.22 of the Health and Safety Code is amended to read:

1366.22. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another

group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security ~~Act, 29~~ *Act (29* U.S.C. ~~Section~~ *Sec.* 1161 et ~~seq.~~ *seq.).*

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service ~~Act, 42~~ *Act (42* U.S.C. Section 300bb-1 et ~~seq.~~ *seq.).*

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 or subdivision ~~(h)~~ *(i)* of Section 1366.25 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.

SEC. 2. Section 1366.24 of the Health and Safety Code is amended to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to

perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article ~~must~~ *shall* request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This

disclosure shall also state that the first premium payment ~~must~~ *shall* equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) ~~Every~~ *A* disclosure issued, amended, or renewed on ~~and after July 1, 2006,~~ *or after July 1, 2016,* for a group benefit plan subject to this article shall include the following notice:

~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."~~

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at

http://www.coveredca.com."

(g) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 3. Section 1366.24 is added to the Health and Safety Code, to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject

to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of either (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the

employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on or after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that

additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) Every disclosure issued, amended, or renewed on or after the operative date of this section for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(g) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following

notice:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at

http://www.coveredca.com."

(h) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law

111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 4. Section 1366.25 of the Health and Safety Code is amended to read:

1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security ~~Act, 29~~ *Act (29* U.S.C. Sec. 1161 et ~~seq.~~ *seq.).*

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may

provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.

(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.

(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation

coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the plan and the employer is being terminated.

(g) (1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision ~~(h)~~ *(i)* to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section

3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at

http://www.coveredca.com."

~~(h)~~

(i) (1) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the

continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision ~~(j).~~ *(k).* For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

~~(i)~~

(j) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

~~(j)~~

(k) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision

(a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the

special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision ~~(h)~~ *(i)* to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

~~(k)~~

(l) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

~~(l)~~

(m) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

~~(m)~~

(n) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

~~(n)~~

(o) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision ~~(h),~~ *(i),* shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

~~(o)~~

(p) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision ~~(h).~~ *(i).* Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written

document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

~~(p)~~

(q) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

(r) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 5. Section 1366.25 is added to the Health and Safety Code, to read:

1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified

beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.

(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.

(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage

is terminated because the group contract between the plan and the employer is being terminated.

(g) (1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision

has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (k) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after the operative date of this section shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(i) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

(j) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (l). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(k) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

(l) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision

(a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for

the special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (j) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

(m) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

(o) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

(p) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (j), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

(q) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision (j). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that

the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(r) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

(s) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

~~SECTION 1.~~

SEC. 6. Section 11801 of the Health and Safety Code is amended to read:

11801. The alcohol and drug program administrator, acting through administrative channels designated pursuant to Section 11795, shall do all of the following:

(a) Coordinate and be responsible for the preparation of the county contract.

(b) Ensure compliance with applicable laws relating to discrimination against any person because of any characteristic listed or defined in Section 11135 of the Government Code.

(c) Submit an annual report to the board of supervisors reporting all activities of the alcohol and other drug program, including a financial accounting of expenditures, number of persons served, and a forecast of anticipated needs for the upcoming year.

(d) Be directly responsible for the administration of all alcohol or other drug program funds allocated to the county under this part, administration of county operated programs, and coordination and monitoring of programs that have contracts with the county to provide alcohol and other drug services.

(e) Ensure the evaluation of alcohol and other drug programs, including the collection of appropriate and necessary client data and program information, pursuant to Chapter 6 (commencing with Section 11825).

(f) Ensure program quality in compliance with appropriate standards pursuant to Chapter 7 (commencing with Section 11830).

(g) Participate and represent the county in meetings of the County Behavioral Health Directors Association of California pursuant to Section 11811.5 for the purposes of representing the counties in their relationship with the state with respect to policies, standards, and administration for alcohol and other drug abuse services.

(h) Perform any other acts that may be necessary, desirable, or proper to carry out the purposes of this part.

SEC. 7. Section 11811.6 of the Health and Safety Code is amended to read:

11811.6. The department shall consult with *county behavioral health directors,* alcohol and drug program~~ administrators~~ *administrators, or both,* in establishing standards pursuant to Chapter 7 (commencing with Section 11830) and regulations pursuant to Chapter 8 (commencing with Section 11835), shall consult with alcohol and drug program administrators on matters of major policy and administration, and may consult with alcohol and drug program administrators on other matters affecting persons with alcohol and other drug problems.~~ The alcohol and drug program administrators may organize, adopt bylaws, and annually~~

~~elect officers.~~ The administrators shall consist of all legally appointed alcohol and drug administrators in the state as designated pursuant to subdivision (a) of Section 11800.

~~SEC. 2.~~

SEC. 8. Section 11830.1 of the Health and Safety Code is amended to read:

11830.1. In order to ensure quality assurance of alcohol and other drug programs and expand the availability of funding resources, the department shall implement a program certification procedure for alcohol and other drug treatment recovery services. The department, after consultation with the County Behavioral Health Directors Association of California, and other interested organizations and individuals, shall develop standards and regulations for the alcohol and other drug treatment recovery services describing the minimal level of service quality required of the service providers to qualify for and obtain state certification. The standards shall be excluded from the rulemaking requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Compliance with these standards shall be voluntary on the part of programs. For the purposes of Section 2626.2 of the Unemployment Insurance Code, certification shall be equivalent to program review.

~~SEC. 3.~~

SEC. 9. Section 11835 of the Health and Safety Code is amended to read:

11835. (a) The purposes of any regulations adopted by the department shall be to implement, interpret, or make specific the provisions of this part and shall not exceed the authority granted to the department pursuant to this part. To the extent possible, the regulations shall be written in clear and concise language and adopted only when necessary to further the purposes of this part.

(b) Except as provided in this section and Sections 11772, 11798, 11798.2, 11814, 11817.8, *and* 11852.5, the department may adopt regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of ~~the~~ Title 2 of the Government Code) necessary for the proper execution of the powers and duties granted to and imposed upon the

department by this part. However, these regulations may be adopted only upon the following conditions:

(1) Prior to adoption of regulations, the department shall consult with the County Behavioral Health Directors Association of California and may consult with any other appropriate persons relating to the proposed regulations.

(2) If an absolute majority of the designated county behavioral health directors who represent counties that have submitted county contracts, vote at a public meeting called by the department, for which 45 days' advance notice shall be given by the department, to reject the proposed regulations, the department shall refer the matter for a decision to a committee, consisting of a representative of the county behavioral health directors, the director, the secretary, and one designee of the secretary. The decision shall be made by a majority vote of this committee at a public meeting convened by the department. Upon a majority vote of the committee recommending adoption of the proposed regulations, the department may then adopt them. Upon a majority vote recommending that the department not adopt the proposed regulations, the department shall then consult again with the County Behavioral Health Directors Association of California and resubmit the proposed regulations to the county behavioral health directors for a vote pursuant to this subdivision.

(3) In the voting process described in paragraph (2), no proxies shall be allowed nor may anyone other than the designated county behavioral health director, director, secretary, and secretary's designee vote at the meetings.

SEC. 10. Section 24100 of the Health and Safety Code is amended to read:

24100. (a) For purposes of this section, the following definitions apply:

(1) "ARRA" means Title III of Division B of the federal American Recovery and Reinvestment Act of 2009 or any amendment to that federal law extending federal premium assistance to qualified beneficiaries, as defined in Section 1366.21 of this code or Section 10128.51 of the Insurance Code.

(2) "Employer" means an employer as defined in Section 1366.21 of this code or an employer as defined in Section 10128.51 of the Insurance Code.

(b) An employer shall provide the information described in subparagraph (B) of paragraph (1) of subdivision ~~(j)~~ *(k)* of Section 1366.25 of this code or subparagraph (B) of paragraph (1) of subdivision ~~(j)~~ *(k)* of Section 10128.55 of the Insurance Code, as applicable, with respect to any employee whose employment is terminated on or after March 2, 2010, and who was enrolled at any time in a health care service plan or health insurance policy offered by the employer on or after September 1, 2008. This information shall be provided to the requesting health care service plan or health insurer within 14 days of receipt of the notification described in paragraph (1) of subdivision ~~(j)~~ *(k)* of Section 1366.25 of this code or paragraph (1) of subdivision ~~(j)~~ *(k)* of Section 10128.55 of the Insurance Code. The employer shall continue to provide the information to the health care service plan or health insurer within 14 days after the end of each month for any employee whose employment is terminated in the prior month until the last date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA.

~~SEC. 4.~~

SEC. 11. Section 103577 of the Health and Safety Code is amended to read:

103577. (a) On or after July 1, 2015, each local registrar or county recorder shall, without an issuance fee or any other associated fee, issue a certified record of live birth to any person who can verify his or her status as a homeless person or a homeless child or youth. A homeless services provider that has knowledge of a person's housing status shall verify a person's status for the purposes of this subdivision. In accordance with all other application requirements as set forth in Section 103526, a request for a certified record of live birth made pursuant to this subdivision shall be made by a homeless person or a homeless child or youth on behalf of themselves, or by any person lawfully entitled to request a certified record of live birth on behalf of a child, if the child has been verified as a homeless person or a homeless child or youth pursuant to this section. A person applying for a certified record of live birth under this subdivision is entitled to one birth record, per application, for each eligible person verified as a homeless person or a homeless child or youth. For purposes of this subdivision, an affidavit developed pursuant to subdivision (b) shall constitute sufficient verification that a person is a homeless

person or a homeless child or youth. A person applying for a certified record of live birth under this subdivision shall not be charged a fee for verification of his or her eligibility.

(b) The State Department of Public Health shall develop an affidavit attesting to an applicant's status as a homeless person or homeless child or youth. For purposes of this section, the affidavit shall not be deemed complete unless it is signed by both the person making a request for a certified record of live birth pursuant to subdivision (a) and a homeless services provider that has knowledge of the applicant's housing status.

(c) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through an all-county letter or similar instructions from the director or State Registrar without taking regulatory action.

(d) For the purposes of this section, the following definitions apply:

(1) A "homeless child or youth" has the same meaning as the definition of "homeless children and youths" as set forth in the federal McKinney-Vento Homeless Assistance Act (42 U.S.C. Sec. 11301 et seq.).

(2) A "homeless person" has the same meaning as the definition of that term set forth in the federal McKinney-Vento Homeless Assistance Act (42 U.S.C. Sec. 11301 et seq.).

(3) A "homeless services provider" includes:

(A) A governmental or nonprofit agency receiving federal, state, or county or municipal funding to provide services to a "homeless person" or "homeless child or youth," or that is otherwise sanctioned to provide those services by a local homeless continuum of care organization.

(B) An attorney licensed to practice law in this state.

(C) A local educational agency liaison for homeless children and youth, pursuant to Section 11432(g)(1)(J)(ii) of Title 42 of the United States Code, or a school social worker.

(D) A human services provider or public social services provider funded by the State of California to provide homeless children or youth services, health services, mental or behavioral health services, substance use disorder services, or public assistance or employment services.

(E) A law enforcement officer designated as a liaison to the homeless population by a local police department or sheriff's department within the state.

~~SEC. 5.~~

SEC. 12. Section 104151 of the Health and Safety Code is amended to read:

104151. (a) Notwithstanding Section 10231.5 of the Government Code, each year, by no later than January 10 and concurrently with the release of the May Revision, the State Department of Health Care Services shall provide the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program. This estimate package shall include all significant assumptions underlying the estimate for the Every Woman Counts Program's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload; a breakout of costs, including, but not limited to, clinical service activities, including office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services; policy changes; contractor information; General Fund, special fund, and federal fund information; and other assumptions necessary to support the estimate.

(b) Notwithstanding Section 10231.5 of the Government Code, each year, the State Department of Health Care Services shall provide the fiscal and appropriate policy committees of the Legislature with quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program. These updates shall be provided no later than November 30, February 28, May 31, and August 31 of each year. The purpose of the updates is to provide the Legislature with the most recent information on the program, and shall include a breakdown of expenditures for each quarter for clinical service activities, including, but not limited to, office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services. This subdivision supersedes the requirements of Section 169 of Chapter 717 of the Statutes of 2010 ~~(S.B. 853).~~ *(SB 853).*

~~SEC. 6.~~

SEC. 13. Section 128456 of the Health and Safety Code is amended to read:

128456. In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the State Department of Health Care Services, the County Behavioral Health Directors Association of California, the California Mental Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

SEC. 14. Section 130302 of the Health and Safety Code is amended to read:

130302. For the purposes of this division, the following definitions apply:

(a) "Director" means the Director of the Office of ~~HIPAA Implementation.~~ *Health Information Integrity.*

(b) "HIPAA" means the federal Health Insurance Portability and Accountability Act.

(c) "Office" means the Office of ~~HIPAA Implementation~~ *Health Information Integrity* established by the office of the Governor in the Health and Human Services Agency.

(d) "State entities" means all state departments, boards, commissions, programs, and other organizational units of the executive branch of state government.

SEC. 15. Section 130304 of the Health and Safety Code is amended to read:

130304. The office shall be under the supervision and control of a director, known as the Director of the Office of ~~HIPAA Implementation,~~ *Health Information Integrity*, who shall be appointed by, and serve at the pleasure of, the Secretary of the Health and Human Services Agency.

~~SEC. 7.~~

SEC. 16. Section 130316 of the Health and Safety Code is repealed.

~~SEC. 8.~~

SEC. 17. Section 130317 of the Health and Safety Code is repealed.

SEC. 18. Section 10128.52 of the Insurance Code is amended to read:

10128.52. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage, or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 10198.6 and 10198.7. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security ~~Act, 29~~ *Act (29* U.S.C. ~~Section~~ *Sec.* 1161 et ~~seq.~~ *seq.).*

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service ~~Act, 42~~ *Act (42* U.S.C. ~~Section~~ *Sec.* 300bb-1 et ~~seq.~~ *seq.).*

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 10128.54 or subdivision ~~(h)~~ *(i)* of Section 10128.55 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 10128.55 and Section 10128.57, in accordance with the terms and conditions of the policy

or contract, or fail to satisfy other terms and conditions of the policy or contract.

SEC. 19. Section 10128.54 of the Insurance Code is amended to read:

10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article ~~must~~ *shall* request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of *either* (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice pursuant to subdivision (e) of Section 10128.55 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified

beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment ~~must~~ *shall* equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this article a new or amended evidence of coverage that includes the disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice

requirements of this section through the provision of the notices to its employer group purchases of benefits.

(e) Every disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.

(f) ~~Every disclosure form~~ *A disclosure* issued, amended, or renewed on~~ and after July 1, 2006,~~ *or after July 1, 2016,* for a group benefit plan subject to this article shall include the following notice:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal at anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at

http://www.coveredca.com."

(g) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education

Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

~~"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."~~

SEC. 20. Section 10128.54 is added to the Insurance Code, to read:

10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of either (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice pursuant to subdivision (e) of Section

10128.55 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this article

a new or amended evidence of coverage that includes the disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchases of benefits.

(e) Every disclosure form issued, amended, or renewed on or after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.

(f) Every disclosure issued, amended, or renewed on or after the operative date of this section for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(g) A disclosure issued, amended, or renewed on or after July 1, 2016, for a group benefit plan subject to this article shall include the following notice:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more

about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

(h) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 21. Section 10128.55 of the Insurance Code is amended to read:

10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the insurer in writing of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 30 days of the qualifying event. The group contract shall also require the employer to notify the insurer, in writing, within 30 days of the date when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security ~~Act, 29~~ *Act (29* U.S.C. Sec. 1161 et ~~seq.~~ *seq.)*.

(b) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 10128.57, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to

the termination or when all enrolled employees are notified, whichever is later.

Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the group benefit plan and those qualified beneficiaries who have been notified, pursuant to Section 10128.54 of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or, disability insurer currently providing continuation coverage to the qualified beneficiary. The successor insurer shall not be obligated to provide this information to qualified beneficiaries if the employer or prior insurer or health care service plan fails to comply with this section.

(d) A disability insurer may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the insurer. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit an insurer to require an employer to perform the administrative obligations of the insurer as required by this article as a condition of the issuance or renewal of coverage.

(e) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying

event, provide to the qualified beneficiary the necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 10128.57, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the insurer and the employer is being terminated.

(g) (1) An insurer shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if an insurer is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall

not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of insurer] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the insurer receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require an insurer to provide the insurer's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require an insurer to amend its existing

evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision ~~(h)~~ *(i)* to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if an insurer previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at

http://www.coveredca.com."

~~(h)~~

(i) (1) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (c) of Section 10708.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision ~~(j).~~ *(k).* For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

~~(i)~~

(j) An insurer shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

~~(j)~~

(k) A health insurer, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The insurer shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the insurer for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the insurer with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the insurer, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the insurer shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health insurer and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the insurer shall provide the

individual with the notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the insurer receives or received information from the individual's previous employer regarding that individual pursuant to Section 24100 of the Health and Safety Code. The insurer shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The insurer shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision ~~(h)~~ *(i)* to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health insurer previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the subsidy under ARRA, the insurer shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health insurer shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. An insurer may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the insurer's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

~~(k)~~

(l) Notwithstanding any other ~~provision of~~ law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under

subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

~~(l)~~

(m) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

~~(m)~~

(n) An insurer that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision ~~(h),~~ *(i),* shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

~~(n)~~

(o) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, an insurer may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) An insurer that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the insurer receives the qualified beneficiary's election notice pursuant to subdivision ~~(h).~~ *(i).* Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the insurer written verification as to whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the insurer a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the insurer to establish that the covered employee's employment was involuntarily terminated for purposes

of ARRA, unless the insurer makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If an insurer requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the insurer receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the insurer shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(p) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become inoperative and is repealed 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 22. Section 10128.55 is added to the Insurance Code, to read:

10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the insurer in writing of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 30 days of the qualifying event. The group contract shall also require the employer to notify the insurer, in writing, within 30 days of the date when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the

Employee Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

(b) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 10128.57, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the group benefit plan and those qualified beneficiaries who have been notified, pursuant to Section 10128.54 of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or, disability insurer currently providing continuation coverage to the qualified beneficiary. The successor insurer shall not be obligated to provide this information to qualified beneficiaries if

the employer or prior insurer or health care service plan fails to comply with this section.

(d) A disability insurer may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the insurer. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit an insurer to require an employer to perform the administrative obligations of the insurer as required by this article as a condition of the issuance or renewal of coverage.

(e) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 10128.57, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the insurer and the employer is being terminated.

(g) (1) An insurer shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity

to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if an insurer is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of insurer] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the insurer receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require an insurer to provide the insurer's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require an insurer to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009–10 Regular Session or by the act amending this section during the second year of the 2009–10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if an insurer previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after the operative date of this section shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(i) A group contract between a group benefit plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 2016, shall require the employer to give the following notice to a qualified beneficiary in connection with a notice regarding election of continuation coverage:

"In addition to your coverage continuation options, you may be eligible for the following:

1. Coverage through the state health insurance marketplace, also known as Covered California. By enrolling through Covered California, you may qualify for lower monthly premiums and lower out-of-pocket costs. Your family members may also qualify for coverage through Covered California.

2. Coverage through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through Medi-Cal. Your family members may also qualify for Medi-Cal.

3. Coverage through an insured spouse. If your spouse has coverage that extends to family members, you may be able to be added on that benefit plan.

Be aware that there is a deadline to enroll in Covered California although you can apply for Medi-Cal anytime. To find out more about how to apply for Covered California and Medi-Cal, visit the Covered California Internet Web site at http://www.coveredca.com."

(j) (1) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (c) of Section 10708.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other law, a qualified beneficiary who is eligible for the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (l). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 10128.57, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other law, a qualified beneficiary who is eligible for any other special election period under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(k) An insurer shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

(l) A health insurer, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The insurer shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the insurer for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the insurer with the name, address, and date of termination of employment for any employee

whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the insurer, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the insurer shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health insurer and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the insurer shall provide the individual with the notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the insurer receives or received information from the individual's previous employer regarding that individual pursuant to Section 24100 of the Health and Safety Code. The insurer shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The insurer shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (j) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health insurer previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the subsidy under ARRA, the insurer shall provide a

written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health insurer shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. An insurer may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the insurer's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

(m) Notwithstanding any other law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

(n) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

(o) An insurer that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (j), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

(p) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, an insurer may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) An insurer that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's

former employer within seven business days from the date the insurer receives the qualified beneficiary's election notice pursuant to subdivision (h). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the insurer written verification as to whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the insurer a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the insurer to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the insurer makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If an insurer requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the insurer receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the insurer shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(q) (1) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative 12 months after the date of that repeal or amendment.

(2) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 23. Section 729.12 of the Welfare and Institutions Code is amended to read:

729.12. (a) It is the intent of the Legislature to authorize an Assessment, Orientation, and Volunteer Mentor Pilot Program in San Diego County. The pilot project will operate under the authority of the county ~~Alcohol and Drug Program Administrator~~ *behavioral health director* in conjunction with the San Diego Juvenile Court and the County of San Diego Probation Department.

(b) Whenever a judge of the San Diego County Juvenile Court or a referee of the San Diego Juvenile Court finds a minor to be a person described in Section 601 or 602 for any reason, the minor may be assessed and screened for drug and alcohol use and abuse; and if the assessment and screening determines the need for drug and alcohol education and intervention, the minor may be required to participate in, and successfully complete, an alcohol and drug orientation, and to participate in, and successfully complete, an alcohol or drug program with a local community-based service provider, as designated by the court.

(c) The Assessment, Orientation, and Volunteer Mentor Pilot Program may operate for a minimum of three years and may screen and assess for drug and alcohol problems, minors who are declared wards of San Diego Juvenile Court.

(d) Drug and alcohol assessments may be conducted utilizing a standardized instrument that shall be approved by the county ~~Alcohol and Drug Program Administrator~~ *behavioral health director* in conjunction with San Diego Juvenile Court and the San Diego County Probation Department.

(e) Those minors who are determined to have drug and alcohol problems, may be required to participate in, and successfully complete, a drug and alcohol orientation. The orientation may provide drug and alcohol education and intervention, referral to community resources for followup education and intervention and arrange for volunteers to serve as mentors to assist each minor in addressing their drug and alcohol problem. Parents or guardians of minors will have the opportunity to participate in the orientation program in order to help juveniles address drug and alcohol use or abuse problems.

(f) As a condition of probation, each minor may be required to submit to drug testing. Drug testing may be conducted on a random basis by a qualified drug and alcohol service provider in

coordination with the county probation department. All contested drug tests may be confirmed by a National Institute for Drug Abuse certified drug laboratory and the findings may be reported to the probation officer for appropriate action. The drug testing protocol may be approved by the county ~~Alcohol and Drug Program Administrator~~ *behavioral health director* in conjunction with San Diego Juvenile Court and the County of San Diego Probation Department.

(g) An evaluation of the pilot program shall be conducted and results of the program shall be submitted to state alcohol and drug programs and to the Legislature at the conclusion of the pilot program. The evaluation shall include, but not be limited to, all of the following:

(1) The number and percentage of juveniles screened.

(2) The number and percentage of juveniles given followup education and intervention.

(3) The number of mentors recruited and trained.

(4) The number and percentage of juveniles assigned to a mentor.

(5) The length of time in an education and intervention program.

(6) The program completion rates.

(7) The number of subsequent violations.

(8) The number of re-arrests.

(9) The urine test results.

(10) The subsequent drug or alcohol use.

(11) The participant's perceptions of program utility.

(12) The provider's perceptions of program utility.

(13) The mentor's perceptions of program utility.

~~SEC. 9.~~

SEC. 24. Section 4033 of the Welfare and Institutions Code is amended to read:

4033. (a) The State Department of Health Care Services shall, to the extent resources are available, comply with the Substance Abuse and Mental Health Services Administration federal planning requirements. The department shall update and issue a state plan, which may also be any federally required state service plan, so that citizens may be informed regarding the implementation of, and long-range goals for, programs to serve mentally ill persons in the state. The department shall gather information from counties necessary to comply with this section.

(b) (1) If the State Department of Health Care Services makes a decision not to comply with any Substance Abuse and Mental Health Services Administration federal planning requirement to which this section applies, the State Department of Health Care Services shall submit the decision, for consultation, to the County Behavioral Health Directors Association of California, the California Mental Health Planning Council, and affected mental health entities.

(2) The State Department of Health Care Services shall not implement any decision not to comply with the Substance Abuse and Mental Health Services Administration federal planning requirements sooner than 30 days after notification of that decision, in writing, by the Department of Finance, to the chairperson of the committee in each house of the Legislature that considers appropriations, and the Chairperson of the Joint Legislative Budget Committee.

~~SEC. 10.~~

SEC. 25. Section 4040 of the Welfare and Institutions Code is amended to read:

4040. The State Department of Health Care Services or State Department of State Hospitals may conduct, or contract for, research or evaluation studies that have application to mental health policy and management issues. In selecting areas for study the department shall be guided by the information needs of state and local policymakers and managers, and suggestions from the County Behavioral Health Directors Association of California.

~~SEC. 11.~~

SEC. 26. Section 4095 of the Welfare and Institutions Code is amended to read:

4095. (a) It is the intent of the Legislature that essential and culturally relevant mental health assessment, case management, and treatment services be available to wards of the court and dependent children of the court placed out of home or who are at risk of requiring out-of-home care. This can be best achieved at the community level through the active collaboration of county social service, probation, education, mental health agencies, and foster care providers.

(b) Therefore, using the Children's Mental Health Services Act (Part 4 (commencing with Section 5850) of Division 5) as a guideline, the State Department of Health Care Services, in

consultation with the County Behavioral Health Directors Association of California, the State Department of Social Services, the County Welfare Directors ~~Association,~~ *Association of California,* the Chief Probation Officers of California, and foster care providers, shall do all of the following:

(1) By July 1, 1994, develop an individualized mental health treatment needs assessment protocol for wards of the court and dependent children of the court.

(2) Define supplemental services to be made available to the target population, including, but not limited to, services defined in Section 540 and following of Title 9 of the California Code of Regulations as of January 1, 1994, family therapy, prevocational services, and crisis support activities.

(3) Establish statewide standardized rates for the various types of services defined by the department in accordance with paragraph (2), and provided pursuant to this section. The rates shall be designed to reduce the impact of competition for scarce treatment resources on the cost and availability of care. The rates shall be implemented only when the state provides funding for the services described in this section.

(4) By January 1, 1994, to the extent state funds are available to implement this section, establish, by regulation, all of the following:

(A) Definitions of priority ranking of subsets of the court wards and dependents target population.

(B) A procedure to certify the mental health programs.

(c) (1) Only those individuals within the target population as defined in regulation and determined to be eligible for services as a result of a mental health treatment needs assessment may receive services pursuant to this section.

(2) Allocation of funds appropriated for the purposes of this section shall be based on the number of wards and dependents and may be adjusted in subsequent fiscal years to reflect costs.

(3) The counties shall be held harmless for failure to provide any assessment, case management, and treatment services to those children identified in need of services for whom there is no funding.

(d) (1) The State Department of Health Care Services shall make information available to the Legislature, on request, on the service populations provided mental health treatment services pursuant to this section, the types and costs of services provided,

and the number of children identified in need of treatment services who did not receive the services.

(2) The information required by paragraph (1) may include information on need, cost, and service impact experience from the following:

(A) Family preservation pilot programs.

(B) Pilot programs implemented under the former Children's Mental Health Services Act, as contained in Chapter 6.8 (commencing with Section 5565.10) of Part 1 of Division 5.

(C) Programs implemented under Chapter 26 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and Section 11401.

(D) County experience in the implementation of Section 4096.

~~SEC. 12.~~

SEC. 27. Section 4096.5 of the Welfare and Institutions Code is amended to read:

4096.5. (a) The State Department of Health Care Services shall make a determination, within 45 days of receiving a request from a group home to be classified at RCL 13 or RCL 14 pursuant to Section 11462.01, to certify or deny certification that the group home program includes provisions for mental health treatment services that meet the needs of seriously emotionally disturbed children. The department shall issue each certification for a period of one year and shall specify the effective date the program met the certification requirements. A program may be recertified if the program continues to meet the criteria for certification.

(b) The State Department of Health Care Services shall, in consultation with County Behavioral Health Directors Association of California and representatives of provider organizations, develop the criteria for the certification required by subdivision (a) by July 1, 1992.

(c) (1) The State Department of Health Care Services may, upon the request of a county, delegate to that county the certification task.

(2) Any county to which the certification task is delegated pursuant to paragraph (1) shall use the criteria and format developed by the department.

(d) The State Department of Health Care Services or delegated county shall notify the State Department of Social Services Community Care Licensing Division immediately upon the

termination of any certification issued in accordance with subdivision (a).

(e) Upon receipt of notification from the State Department of Social Services Community Care Licensing Division of any adverse licensing action taken after the finding of noncompliance during an inspection conducted pursuant to Section 1538.7 of the Health and Safety Code, the State Department of Health Care Services or the delegated county shall review the certification issued pursuant to this section.

SEC. 28. Section 4117 of the Welfare and Institutions Code, as amended by Section 47 of Chapter 26 of the Statutes of 2015, is amended to read:

4117. (a) Whenever a trial is had of any person charged with escape or attempt to escape from a state hospital, whenever a hearing is had on the return of a writ of habeas corpus prosecuted by or on behalf of any person confined in a state hospital except in a proceeding to which Section 5110 applies, whenever a hearing is had on a petition under Section 1026.2, subdivision (b) of Section 1026.5, Section 2966, or Section 2972 of the Penal Code, Section 7361 of this code, or former Section 6316.2 of this code for the release of a person confined in a state hospital, whenever a hearing is had for an order seeking involuntary treatment with psychotropic medication, or any other medication for which an order is required, of a person confined in a state hospital pursuant to Section 2962 of the Penal Code, and whenever a person confined in a state hospital is tried for a crime committed therein, the appropriate financial officer or other designated official of the county in which the trial or hearing is had shall make out a statement of all mental health treatment costs and shall make out a separate statement of all nontreatment costs incurred by the county for investigation and other preparation for the trial or hearing, and the actual trial or hearing, all costs of maintaining custody of the patient and transporting him or her to and from the hospital, and costs of appeal. The statements shall be properly certified by a judge of the superior court of that county. The statement of mental health treatment costs shall be sent to the State Department of State Hospitals and the statement of all nontreatment costs, except as provided in subdivision (c), shall be sent to the Controller for approval. After approval, the department shall cause the amount of mental health treatment costs incurred on or after July 1, 1987,

to be paid to the county ~~mental~~ *behavioral* health director or his or her designee ~~where~~ *when* the trial or hearing was held out of the money appropriated for this purpose by the Legislature. In addition, the Controller shall cause the amount of all nontreatment costs incurred on and after July 1, 1987, to be paid out of the money appropriated by the Legislature, to the county treasurer of the county where the trial or hearing was had.

(b) Commencing January 1, 2012, the nontreatment costs associated with Section 2966 of the Penal Code and approved by the Controller, as required by subdivision (a), shall be paid by the Department of Corrections and Rehabilitation pursuant to Section 4750 of the Penal Code.

(c) The nontreatment costs associated with any hearing for an order seeking involuntary treatment with psychotropic medication, or any other medication for which an order is required, of a person confined in a state hospital pursuant to Section 1026, 1026.5, or 2972 of the Penal Code, as provided in subdivision (a), shall be paid by the county of commitment. As used in this subdivision, "county of commitment" means the county seeking the continued treatment of a mentally disordered offender pursuant to Section 2972 of the Penal Code or the county committing a patient who has been found not guilty by reason of insanity pursuant to Section 1026 or 1026.5 of the Penal Code. The appropriate financial officer or other designated official of the county in which the proceeding is held shall make out a statement of all of the costs incurred by the county for the investigation, preparation, and conduct of the proceedings, and the costs of appeal, if any. The statement shall be certified by a judge of the superior court of the county. The statement shall then be sent to the county of commitment, which shall reimburse the county providing the services.

(d) (1) Whenever a hearing is held pursuant to Section 1604, 1608, 1609, or 2966 of the Penal Code, all transportation costs to and from a state hospital or a facility designated by the community program director during the hearing shall be paid by the Controller as provided in this subdivision. The appropriate financial officer or other designated official of the county in which a hearing is held shall make out a statement of all transportation costs incurred by the county. The statement shall be properly certified by a judge of the superior court of that county and sent to the Controller for approval. The Controller shall cause the amount of transportation

costs incurred on and after July 1, 1987, to be paid to the county treasurer of the county where the hearing was had out of the money appropriated by the Legislature.

(2) As used in this subdivision, "community program director" means the person designated pursuant to Section 1605 of the Penal Code.

SEC. 29. Section 5121 of the Welfare and Institutions Code is amended to read:

5121. The county ~~mental~~ *behavioral* health director may develop procedures for the county's designation and training of professionals who will be designated to perform functions under Section 5150. These procedures may include, but are not limited to, the following:

(a) The license types, practice disciplines, and clinical experience of professionals eligible to be designated by the county.

(b) The initial and ongoing training and testing requirements for professionals eligible to be designated by the county.

(c) The application and approval processes for professionals seeking to be designated by the county, including the timeframe for initial designation and procedures for renewal of the designation.

(d) The county's process for monitoring and reviewing professionals designated by the county to ensure appropriate compliance with state law, regulations, and county procedures.

SEC. 30. Section 5150 of the Welfare and Institutions Code is amended to read:

5150. (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. At a minimum, assessment, as defined in Section 5150.4, and evaluation, as defined in subdivision (a) of Section

5008, shall be conducted and provided on an ongoing basis. Crisis intervention, as defined in subdivision (e) of Section 5008, may be provided concurrently with assessment, evaluation, or any other service.

(b) The professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county shall assess the person to determine whether he or she can be properly served without being detained. If in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. Nothing in this subdivision shall be interpreted to prevent a peace officer from delivering individuals to a designated facility for assessment under this section. Furthermore, the assessment requirement of this subdivision shall not be interpreted to require peace officers to perform any additional duties other than those specified in Sections 5150.1 and 5150.2.

(c) Whenever a person is evaluated by a professional person in charge of a facility designated by the county for evaluation or treatment, member of the attending staff, or professional person designated by the county and is found to be in need of mental health services, but is not admitted to the facility, all available alternative services provided pursuant to subdivision (b) shall be offered as determined by the county ~~mental~~ *behavioral* health director.

(d) If, in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or the professional person designated by the county, the person cannot be properly served without being detained, the admitting facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, and stating that the peace officer, professional person in charge of the facility

designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county has probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person shall be liable in a civil action for intentionally giving a statement ~~which~~ *that* he or she knows to be false.

(e) At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person. The person taking him or her into custody shall then furnish to the court a report generally describing the person's property so preserved and safeguarded and its disposition, in substantially the form set forth in Section 5211, except that if a responsible relative or the guardian or conservator of the person is in possession of the person's property, the report shall include only the name of the relative or guardian or conservator and the location of the property, whereupon responsibility of the person taking him or her into custody for that property shall terminate. As used in this section, "responsible relative" includes the spouse, parent, adult child, domestic partner, grandparent, grandchild, or adult brother or sister of the person.

(f) (1) Each person, at the time he or she is first taken into custody under this section, shall be provided, by the person who takes him or her into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing. The information shall be in substantially the following form:

My name is _____ .

I am a _____ .

(peace officer/mental health professional)

with _____ .
(name of agency)
You are not under criminal arrest, but I am taking you for an examination by mental health professionals at _____ .
_____
(name of facility)
You will be told your rights by the mental health staff.

(2) If taken into custody at his or her own residence, the person shall also be provided the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

(g) The designated facility shall keep, for each patient evaluated, a record of the advisement given pursuant to subdivision (f) which shall include all of the following:

(1) The name of the person detained for evaluation.

(2) The name and position of the peace officer or mental health professional taking the person into custody.

(3) The date the advisement was completed.

(4) Whether the advisement was completed.

(5) The language or modality used to give the advisement.

(6) If the advisement was not completed, a statement of good cause, as defined by regulations of the State Department of Health Care Services.

(h) (1) Each person admitted to a facility designated by the county for evaluation and treatment shall be given the following information by admission staff of the facility. The information shall be given orally and in writing and in a language or modality accessible to the person. The written information shall be available to the person in English and in the language that is the person's primary means of communication. Accommodations for other disabilities that may affect communication shall also be provided. The information shall be in substantially the following form:

My name is _____ .

My position here is _____.

You are being placed into this psychiatric facility because it is our professional opinion that, as a result of a mental health disorder, you are likely to (check applicable):

□ Harm yourself.

□ Harm someone else.

□ Be unable to take care of your own food, clothing, and housing needs.

We believe this is true because

_____

(list of the facts upon which the allegation of dangerous or gravely disabled due to mental health disorder is based, including pertinent facts arising from the admission interview).

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at _____

(phone number for the county Patients' Rights Advocacy office)

Your 72-hour period began _____.

(date/time)

(2) If the notice is given in a county where weekends and holidays are excluded from the 72-hour period, the patient shall be informed of this fact.

(i) For each patient admitted for evaluation and treatment, the facility shall keep with the patient's medical record a record of the advisement given pursuant to subdivision (h), which shall include all of the following:

(1) The name of the person performing the advisement.
(2) The date of the advisement.
(3) Whether the advisement was completed.
(4) The language or modality used to communicate the advisement.
(5) If the advisement was not completed, a statement of good cause.

SEC. 31. Section 5152.1 of the Welfare and Institutions Code is amended to read:

5152.1. The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county ~~mental~~ *behavioral* health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the following conditions apply:

(a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

(b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release.

If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after receipt of notification.

SEC. 32. Section 5152.2 of the Welfare and Institutions Code is amended to read:

5152.2. Each law enforcement agency within a county shall arrange with the county ~~mental~~ *behavioral* health director a method for giving prompt notification to peace officers pursuant to Section 5152.1.

SEC. 33. Section 5250.1 of the Welfare and Institutions Code is amended to read:

5250.1. The professional person in charge of a facility providing intensive treatment, pursuant to Section 5250 or 5270.15, or that person's designee, shall notify the county ~~mental~~ *behavioral* health director, or the director's designee, and the peace officer who made the original written application for 72-hour evaluation pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, that the person admitted pursuant to the application has been released unconditionally if all of the following conditions apply:

(a) The peace officer has requested notification at the time he or she makes the application for 72-hour evaluation.

(b) The peace officer has certified in writing at the time he or she made the application that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

(c) The notice is limited to the person's name, address, date of admission for 72-hour evaluation, date of certification for intensive treatment, and date of release.

If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after receipt of notification.

SEC. 34. Section 5305 of the Welfare and Institutions Code is amended to read:

5305. (a) Any person committed pursuant to Section 5300 may be placed on outpatient status if all of the following conditions are satisfied:

(1) In the evaluation of the superintendent or professional person in charge of the licensed health facility, the person named in the petition will no longer be a danger to the health and safety of others while on outpatient status and will benefit from outpatient status.

(2) The county ~~mental~~ *behavioral* health director advises the court that the person named in the petition will benefit from outpatient status and identifies an appropriate program of supervision and treatment.

(b) After actual notice to the public officer, pursuant to Section 5114, and to counsel of the person named in the petition, to the court and to the county ~~mental~~ *behavioral* health director, the plan

for outpatient treatment shall become effective within five judicial days unless a court hearing on that action is requested by any of the aforementioned parties, in which case the release on outpatient status shall not take effect until approved by the court after a hearing. This hearing shall be held within five judicial days of the actual notice required by this subdivision.

(c) The county ~~mental~~ *behavioral* health director shall be the outpatient supervisor of persons placed on outpatient status under ~~provisions of~~ this section. The county ~~mental~~ *behavioral* health director may delegate ~~such~~ outpatient supervision responsibility to a designee.

(d) The outpatient treatment supervisor shall, ~~where~~ *when* the person is placed on outpatient status at least three months, submit at 90-day intervals to the court, the public officer, pursuant to Section 5114, and counsel of the person named in the petition and to the supervisor or professional person in charge of the licensed health facility, ~~where~~ *when* appropriate, a report setting forth the status and progress of the person named in the petition. Notwithstanding the length of the outpatient status, a final report shall be submitted by the outpatient treatment supervisor at the conclusion of the 180-day commitment setting forth the status and progress of the person.

SEC. 35. Section 5306.5 of the Welfare and Institutions Code is amended to read:

5306.5. (a) If at any time during the outpatient period, the outpatient treatment supervisor is of the opinion that the person receiving treatment requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision, the county ~~mental~~ *behavioral* health director shall notify the superior court in either the county ~~which~~ *that* approved outpatient status or in the county where outpatient treatment is being provided of ~~such~~ *that* opinion by means of a written request for revocation of outpatient status. The county ~~mental~~ *behavioral* health director shall furnish a copy of this request to the counsel of the person named in the request for revocation and to the public officer, pursuant to Section 5114, in both counties if the request is made in the county of treatment, rather than the county of commitment.

(b) Within 15 judicial days, the court where the request was filed shall hold a hearing and shall either approve or disapprove the request for revocation of outpatient status. If the court approves

the request for revocation, the court shall order that the person be confined in a state hospital or other treatment facility approved by the county ~~mental~~ *behavioral* health director. The court shall transmit a copy of its order to the county ~~mental~~ *behavioral* health director or a designee and to the Director of State Hospitals. ~~Where~~ *When* the county of treatment and the county of commitment differ and revocation occurs in the county of treatment, the court shall enter the name of the committing county and its case number on the order of revocation and shall send a copy of the order to the committing court and the public officer, pursuant to Section 5114, and counsel of the person named in the request for revocation in the county of commitment.

SEC. 36. Section 5307 of the Welfare and Institutions Code is amended to read:

5307. If at any time during the outpatient period the public officer, pursuant to Section 5114, is of the opinion that the person is a danger to the health and safety of others while on outpatient status, the public officer, pursuant to Section 5114, may petition the court for a hearing to determine whether the person shall be continued on outpatient status. Upon receipt of the petition, the court shall calendar the case for further proceedings within 15 judicial days and the clerk shall notify the person, the county ~~mental~~ *behavioral* health director, and the attorney of record for the person of the hearing date. Upon failure of the person to appear as noticed, if a proper affidavit of service and advisement has been filed with the court, the court may issue a body attachment for ~~such~~ *that* person. If, after a hearing in court the judge determines that the person is a danger to the health and safety of others, the court shall order that the person be confined in a state hospital or other treatment facility ~~which~~ *that* has been approved by the county ~~mental~~ *behavioral* health director.

SEC. 37. Section 5308 of the Welfare and Institutions Code is amended to read:

5308. Upon the filing of a request for revocation of outpatient status under Section 5306.5 or 5307 and pending the court's decision on revocation, the person subject to revocation may be confined in a state hospital or other treatment facility by the county ~~mental~~ *behavioral* health director when it is the opinion of that director that the person will now be a danger to self or to another while on outpatient status and that to delay hospitalization until

the revocation hearing would pose a demonstrated danger of harm to the person or to another. Upon the request of the county ~~mental~~ *behavioral* health director or a designee, a peace officer shall take, or cause to be taken, the person into custody and transport the person to a treatment facility for hospitalization under this section. The county ~~mental~~ *behavioral* health director shall notify the court in writing of the admission of the person to inpatient status and of the factual basis for the opinion that ~~such~~ immediate return to inpatient treatment was necessary. The court shall supply a copy of these documents to the public officer, pursuant to Section 5114, and counsel of the person subject to revocation.

A person hospitalized under this section shall have the right to judicial review of the detention in the manner prescribed in Article 5 (commencing with Section 5275) of Chapter 2 and to an explanation of rights in the manner prescribed in Section 5252.1.

Nothing in this section shall prevent hospitalization pursuant to the provisions of Section 5150, 5250, 5350, or 5353.

A person whose confinement in a treatment facility under Section 5306.5 or 5307 is approved by the court shall not be released again to outpatient status unless court approval is obtained under Section 5305.

~~SEC. 13.~~

SEC. 38. Section 5326.95 of the Welfare and Institutions Code is amended to read:

5326.95. The Director of State Hospitals shall adopt regulations to carry out the provisions of this chapter, including standards defining excessive use of convulsive ~~treatment~~ *treatment*, which shall be developed in consultation with the State Department of Health Care Services and the County Behavioral Health Directors Association of California.

SEC. 39. Section 5328 of the Welfare and Institutions Code is amended to read:

5328. All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential. Information and records obtained in the course of providing similar

services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator, shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.

(b) When the patient, with the approval of the physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, or licensed professional clinical counselor, who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family. Nothing in this subdivision shall be construed to authorize a licensed marriage and family therapist or licensed professional clinical counselor to provide services or to be in charge of a patient's care beyond his or her lawful scope of practice.

(c) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) If the recipient of services is a minor, ward, dependent, or conservatee, and his or her parent, guardian, guardian ad litem, conservator, or authorized representative designates, in writing, persons to whom records or information may be disclosed, except that nothing in this article shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(e) For research, provided that the Director of Health Care Services, the Director of State Hospitals, the Director of Social Services, or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

_____

Date

As a condition of doing research concerning persons who have received services from ____ (fill in the facility, agency or person), I, ____, agree to obtain the prior informed consent of such persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Senate Committee on Rules or the Assembly Committee on Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff

of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the patient, may release all information and records relating to the patient except that nothing in this article shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(k) Upon written agreement by a person previously confined in or otherwise treated by a facility, the professional person in charge of the facility or his or her designee may release any information, except information that has been given in confidence by members of the person's family, requested by a probation officer charged with the evaluation of the person after his or her conviction of a crime if the professional person in charge of the facility determines that the information is relevant to the evaluation. The agreement shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this subdivision shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.

(*l*) (1) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the provision of child welfare services or the investigation, prevention, identification, management, or treatment of child abuse or neglect pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9. Information obtained pursuant to this subdivision shall not be used in any criminal or delinquency proceeding. Nothing in this subdivision shall prohibit evidence identical to that contained within the records from being admissible in a criminal or delinquency proceeding, if the evidence is derived solely from means other than this subdivision, as permitted by law.

(2) As used in this subdivision, "child welfare services" means those services that are directed at preventing child abuse or neglect.

(m) To county patients' rights advocates who have been given knowing voluntary authorization by a client or a guardian ad litem. The client or guardian ad litem, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate.

(n) To a committee established in compliance with Section 14725.

(o) In providing information as described in Section 7325.5. Nothing in this subdivision shall permit the release of any information other than that described in Section 7325.5.

(p) To the county ~~mental~~ *behavioral* health director or the director's designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(q) If the patient gives his or her consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 125135 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this subdivision, "qualified professional persons" means those persons with the qualifications necessary to carry out the genetic counseling duties under this subdivision as determined by the genetic disease unit established in the State Department of Health Care Services under Section 125000 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this subdivision after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(r) When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, "psychotherapist" means anyone so defined within Section 1010 of the Evidence Code.

(s) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency

response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the federal Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(2) For purposes of this subdivision, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the federal Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

(t) (1) To a law enforcement officer who personally lodges with a facility, as defined in paragraph (2), a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.

(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a person with mental illness subject to this section.

(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.

(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for individuals with mental illness, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(u) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to Section 15610.55, 15753.5, or 15761. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused elder or dependent adult pursuant to Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

(x) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer's legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients' rights advocate, and the consumer, the consumer's legal representative, or the clients' rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.

(ii) The appointing authority, the person against whom the adverse action has been taken, and the person's representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(III) Requires the parties to submit the stipulation to the administrative tribunal with jurisdiction over the adverse action at the earliest possible opportunity.

(2) For the purposes of this subdivision, the State Personnel Board may, prior to any appeal from adverse action being filed with it, issue a protective order, upon application by the appointing authority, for the limited purpose of prohibiting the parties from disclosing or using information or records for any purpose other than the proceeding for which the information or records were requested or provided, and to require the employee or the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final, except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representatives because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(3) Individual identifiers, including, but not limited to, names, social security numbers, and hospital numbers, that are not

necessary for the prosecution or defense of the adverse action, shall not be disclosed.

(4) All records, documents, or other materials containing confidential information protected by this section that have been submitted or otherwise disclosed to the administrative agency or other person as a component of an appeal from an adverse action shall, upon proper motion by the appointing authority to the administrative tribunal, be placed under administrative seal and shall not, thereafter, be subject to disclosure to any person or entity except upon the issuance of an order of a court of competent jurisdiction.

(5) For purposes of this subdivision, an adverse action becomes final when the employee fails to answer within the time specified in Section 19575 of the Government Code, or, after filing an answer, withdraws the appeal, or, upon exhaustion of the administrative appeal or of the judicial review remedies as otherwise provided by law.

(y) To the person appointed as the developmental services decisionmaker for a minor, dependent, or ward pursuant to Section 319, 361, or 726.

SEC. 40. Section 5328.2 of the Welfare and Institutions Code is amended to read:

5328.2. Notwithstanding Section 5328, movement and identification information and records regarding a patient who is committed to the department, state hospital, or any other public or private mental health facility approved by the county ~~mental~~ *behavioral* health director for observation or for an indeterminate period as a mentally disordered sex offender, or for a person who is civilly committed as a sexually violent predator pursuant to Article 4 (commencing with Section 6600) of Chapter 2 of Part 2 of Division 6, or regarding a patient who is committed to the department, to a state hospital, or any other public or private mental health facility approved by the county ~~mental~~ *behavioral* health director under Section 1026 or 1370 of the Penal Code or receiving treatment pursuant to Section 5300 of this code, shall be forwarded immediately without prior request to the Department of Justice. Except as otherwise provided by law, information automatically reported under this section shall be restricted to name, address, fingerprints, date of admission, date of discharge, date of escape or return from escape, date of any home leave, parole or leave of

absence and, if known, the county in which the person will reside upon release. The Department of Justice may in turn furnish information reported under this section pursuant to Section 11105 or 11105.1 of the Penal Code. It shall be a misdemeanor for recipients furnished with this information to in turn furnish the information to any person or agency other than those specified in Section 11105 or 11105.1 of the Penal Code.

SEC. 41. Section 5346 of the Welfare and Institutions Code is amended to read:

5346. (a) In any county in which services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health

department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.

(9) It is likely that the person will benefit from assisted outpatient treatment.

(b) (1) A petition for an order authorizing assisted outpatient treatment may be filed by the county ~~mental~~ *behavioral* health director, or his or her designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.

(2) A request may be made only by any of the following persons to the county mental health department for the filing of a petition to obtain an order authorizing assisted outpatient treatment:

(A) Any person 18 years of age or older with whom the person who is the subject of the petition resides.

(B) Any person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.

(C) The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.

(D) The director of a hospital in which the person who is the subject of the petition is hospitalized.

(E) A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.

(F) A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition.

(3) Upon receiving a request pursuant to paragraph (2), the county ~~mental~~ *behavioral* health director shall conduct an investigation into the appropriateness of the filing of the petition. The director shall file the petition only if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.

(4) The petition shall state all of the following:

(A) Each of the criteria for assisted outpatient treatment as set forth in subdivision (a).

(B) Facts that support the petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition shall be limited to the stated facts in the verified petition, and the petition contains all the grounds on which the petition is based, in order to ensure adequate notice to the person who is the subject of the petition and his or her counsel.

(C) That the person who is the subject of the petition is present, or is reasonably believed to be present, within the county where the petition is filed.

(D) That the person who is the subject of the petition has the right to be represented by counsel in all stages of the proceeding under the petition, in accordance with subdivision (c).

(5) The petition shall be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director who shall state, if applicable, either of the following:

(A) That the licensed mental health treatment provider has personally examined the person who is the subject of the petition no more than 10 days prior to the submission of the petition, the facts and reasons why the person who is the subject of the petition meets the criteria in subdivision (a), that the licensed mental health treatment provider recommends assisted outpatient treatment for the person who is the subject of the petition, and that the licensed mental health treatment provider is willing and able to testify at the hearing on the petition.

(B) That no more than 10 days prior to the filing of the petition, the licensed mental health treatment provider, or his or her designee, has made appropriate attempts to elicit the cooperation of the person who is the subject of the petition, but has not been successful in persuading that person to submit to an examination,

that the licensed mental health treatment provider has reason to believe that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and that the licensed mental health treatment provider is willing and able to examine the person who is the subject of the petition and testify at the hearing on the petition.

(c) The person who is the subject of the petition shall have the right to be represented by counsel at all stages of a proceeding commenced under this section. If the person so elects, the court shall immediately appoint the public defender or other attorney to assist the person in all stages of the proceedings. The person shall pay the cost of the legal services if he or she is able.

(d) (1) Upon receipt by the court of a petition submitted pursuant to subdivision (b), the court shall fix the date for a hearing at a time not later than five days from the date the petition is received by the court, excluding Saturdays, Sundays, and holidays. The petitioner shall promptly cause service of a copy of the petition, together with written notice of the hearing date, to be made personally on the person who is the subject of the petition, and shall send a copy of the petition and notice to the county office of patient rights, and to the current health care provider appointed for the person who is the subject of the petition, if any such provider is known to the petitioner. Continuances shall be permitted only for good cause shown. In granting continuances, the court shall consider the need for further examination by a physician or the potential need to provide expeditiously assisted outpatient treatment. Upon the hearing date, or upon any other date or dates to which the proceeding may be continued, the court shall hear testimony. If it is deemed advisable by the court, and if the person who is the subject of the petition is available and has received notice pursuant to this section, the court may examine in or out of court the person who is the subject of the petition who is alleged to be in need of assisted outpatient treatment. If the person who is the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the person have failed, the court may conduct the hearing in the person’s absence. If the hearing is conducted without the person present, the court shall set forth the factual basis for conducting the hearing without the person’s presence.

(2) The court shall not order assisted outpatient treatment unless an examining licensed mental health treatment provider, who has personally examined, and has reviewed the available treatment history of, the person who is the subject of the petition within the time period commencing 10 days before the filing of the petition, testifies in person at the hearing.

(3) If the person who is the subject of the petition has refused to be examined by a licensed mental health treatment provider, the court may request that the person consent to an examination by a licensed mental health treatment provider appointed by the court. If the person who is the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order any person designated under Section 5150 to take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital for examination by a licensed mental health treatment provider as soon as is practicable. Detention of the person who is the subject of the petition under the order may not exceed 72 hours. If the examination is performed by another licensed mental health treatment provider, the examining licensed mental health treatment provider may consult with the licensed mental health treatment provider whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the person meets the criteria for assisted outpatient treatment.

(4) The person who is the subject of the petition shall have all of the following rights:

(A) To adequate notice of the hearings to the person who is the subject of the petition, as well as to parties designated by the person who is the subject of the petition.

(B) To receive a copy of the court-ordered evaluation.

(C) To counsel. If the person has not retained counsel, the court shall appoint a public defender.

(D) To be informed of his or her right to judicial review by habeas corpus.

(E) To be present at the hearing unless he or she waives the right to be present.

(F) To present evidence.

(G) To call witnesses on his or her behalf.

(H) To cross-examine witnesses.

(I) To appeal decisions, and to be informed of his or her right to appeal.

(5) (A) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(B) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court may order the person who is the subject of the petition to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specify that the proposed treatment is the least restrictive treatment appropriate and feasible for the person who is the subject of the petition. The order shall state the categories of assisted outpatient treatment, as set forth in Section 5348, that the person who is the subject of the petition is to receive, and the court may not order treatment that has not been recommended by the examining licensed mental health treatment provider and included in the written treatment plan for assisted outpatient treatment as required by subdivision (e). If the person has executed an advance health care directive pursuant to Chapter 2 (commencing with Section 4650) of Part 1 of Division 4.7 of the Probate Code, any directions included in the advance health care directive shall be considered in formulating the written treatment plan.

(6) If the person who is the subject of a petition for an order for assisted outpatient treatment pursuant to subparagraph (B) of paragraph (5) of subdivision (d) refuses to participate in the assisted outpatient treatment program, the court may order the person to meet with the assisted outpatient treatment team designated by the director of the assisted outpatient treatment program. The treatment team shall attempt to gain the person’s cooperation with treatment ordered by the court. The person may be subject to a 72-hour hold pursuant to subdivision (f) only after the treatment team has attempted to gain the person’s cooperation with treatment ordered by the court, and has been unable to do so.

(e) Assisted outpatient treatment shall not be ordered unless the licensed mental health treatment provider recommending assisted outpatient treatment to the court has submitted to the court a written

treatment plan that includes services as set forth in Section 5348, and the court finds, in consultation with the county ~~mental~~ *behavioral* health director, or his or her designee, all of the following:

(1) That the services are available from the county, or a provider approved by the county, for the duration of the court order.

(2) That the services have been offered to the person by the local director of mental health, or his or her designee, and the person has been given an opportunity to participate on a voluntary basis, and the person has failed to engage in, or has refused, treatment.

(3) That all of the elements of the petition required by this article have been met.

(4) That the treatment plan will be delivered to the county ~~director of mental health,~~ *behavioral health director,* or to his or her appropriate designee.

(f) If, in the clinical judgment of a licensed mental health treatment provider, the person who is the subject of the petition has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the licensed mental health treatment provider, efforts were made to solicit compliance, and, in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation, the provider may request that persons designated under Section 5150 take into custody the person who is the subject of the petition and transport him or her, or cause him or her to be transported, to a hospital, to be held up to 72 hours for examination by a licensed mental health treatment provider to determine if the person is in need of treatment pursuant to Section 5150. Any continued involuntary retention in a hospital beyond the initial 72-hour period shall be pursuant to Section 5150. If at any time during the 72-hour period the person is determined not to meet the criteria of Section 5150, and does not agree to stay in the hospital as a voluntary patient, he or she shall be released and any subsequent involuntary detention in a hospital shall be pursuant to Section 5150. Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary civil commitment or a finding that the person who is the subject of the petition is in contempt of court.

(g) If the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director shall apply to the court, prior to the expiration of the period of the initial assisted outpatient treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with subdivisions (a) to (f), inclusive. The period for further involuntary outpatient treatment authorized by any subsequent order under this subdivision may not exceed 180 days from the date of the order.

(h) At intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program shall file an affidavit with the court that ordered the outpatient treatment affirming that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment. At these times, the person who is the subject of the order shall have the right to a hearing on whether or not he or she still meets the criteria for assisted outpatient treatment if he or she disagrees with the director's affidavit. The burden of proof shall be on the director.

(i) During each 60-day period specified in subdivision (h), if the person who is the subject of the order believes that he or she is being wrongfully retained in the assisted outpatient treatment program against his or her wishes, he or she may file a petition for a writ of habeas corpus, thus requiring the director of the assisted outpatient treatment program to prove that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.

(j) Any person ordered to undergo assisted outpatient treatment pursuant to this article, who was not present at the hearing at which the order was issued, may immediately petition the court for a writ of habeas corpus. Treatment under the order for assisted outpatient treatment may not commence until the resolution of that petition.

~~SEC. 14.~~

SEC. 42. Section 5400 of the Welfare and Institutions Code is amended to read:

5400. (a) The Director of Health Care Services shall administer this part and shall adopt rules, regulations, and standards as necessary. In developing rules, regulations, and standards, the

Director of Health Care Services shall consult with the County Behavioral Health Directors Association of California, the California Mental Health Planning Council, and the office of the Attorney General. Adoption of these standards, rules, and regulations shall require approval by the County Behavioral Health Directors Association of California by majority vote of those present at an official session.

(b) Wherever feasible and appropriate, rules, regulations, and standards adopted under this part shall correspond to comparable rules, regulations, and standards adopted under the Bronzan-McCorquodale Act. These corresponding rules, regulations, and standards shall include qualifications for professional personnel.

(c) Regulations adopted pursuant to this part may provide standards for services for persons with chronic alcoholism that differ from the standards for services for persons with mental health disorders.

~~SEC. 15.~~

SEC. 43. Section 5585.22 of the Welfare and Institutions Code is amended to read:

5585.22. The Director of Health Care Services, in consultation with the County Behavioral Health Directors Association of California, may develop the appropriate educational materials and a training curriculum, and may provide training as necessary to ensure that those persons providing services pursuant to this part fully understand its purpose.

~~SEC. 16.~~

SEC. 44. Section 5601 of the Welfare and Institutions Code is amended to read:

5601. As used in this part:

(a) "Governing body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly; and in the case of a city, the city council or city councils acting jointly.

(b) "Conference" means the County Behavioral Health Directors Association of California as established under former Section 5757.

(c) Unless the context requires otherwise, "to the extent resources are available" means to the extent that funds deposited in the mental health account of the local health and welfare fund are available to an entity qualified to use those funds.

(d) "Part 1" refers to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)).

(e) "Director of Health Care Services" or "director" means the Director of the State Department of Health Care Services.

(f) "Institution" includes a general acute care hospital, a state hospital, a psychiatric hospital, a psychiatric health facility, a skilled nursing facility, including an institution for mental disease as described in Chapter 1 (commencing with Section 5900) of Part 5, an intermediate care facility, a community care facility or other residential treatment facility, or a juvenile or criminal justice institution.

(g) "Mental health service" means any service directed toward early intervention in, or alleviation or prevention of, mental disorder, including, but not limited to, diagnosis, evaluation, treatment, personal care, day care, respite care, special living arrangements, community skill training, sheltered employment, socialization, case management, transportation, information, referral, consultation, and community services.

~~SEC. 17.~~

SEC. 45. Section 5611 of the Welfare and Institutions Code is amended to read:

5611. (a) The Director of ~~Mental Health~~ *State Hospitals* shall establish a Performance Outcome Committee, to be comprised of representatives from the ~~PL~~ *Public Law* 99-660 Planning Council and the County Behavioral Health Directors Association of California. Any costs associated with the performance of the duties of the committee shall be absorbed within the resources of the participants.

(b) Major mental health professional organizations representing licensed clinicians may participate as members of the committee at their own expense.

(c) The committee may seek private funding for costs associated with the performance of its duties.

~~SEC. 18.~~

SEC. 46. Section 5664 of the Welfare and Institutions Code is amended to read:

5664. In consultation with the County Behavioral Health Directors Association of California, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning

Council, and the California Health and Human Services Agency, county ~~mental~~ *behavioral* health systems shall provide reports and data to meet the information needs of the state, as necessary.

SEC. 47. Section 5694.7 of the Welfare and Institutions Code is amended to read:

5694.7. When the director of ~~mental~~ *behavioral* health in a county is notified pursuant to Section 319.1 or 635.1, or Section 7572.5 of the Government Code about a specific case, the county ~~mental~~ *behavioral* health director shall assign the responsibility either directly or through contract with a private provider, to review the information and assess whether or not the child is seriously emotionally disturbed as well as to determine the level of involvement in the case needed to assure access to appropriate mental health treatment services and whether appropriate treatment is available through the minor's own resources, those of the family or another private party, including a third-party payer, or through another agency, and to ensure access to services available within the county's program. This determination shall be submitted in writing to the notifying agency within 30 days. If in the course of evaluating the minor, the county ~~mental~~ *behavioral* health director determines that the minor may be dangerous, the county ~~mental~~ *behavioral* health director may request the court to direct counsel not to reveal information to the minor relating to the name and address of the person who prepared the subject report. If appropriate treatment is not available within the county's Bronzan-McCorquodale program, nothing in this section shall prevent the court from ordering treatment directly or through a family's private resources.

~~SEC. 19.~~

SEC. 48. Section 5701.1 of the Welfare and Institutions Code is amended to read:

5701.1. Notwithstanding Section 5701, the State Department of Health Care Services, in consultation with the County Behavioral Health Directors Association of California and the California Mental Health Planning Council, may utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the State Department of Health Care Services, above the funding level provided in federal fiscal year 1998, for the development of innovative programs for identified target populations, upon appropriation by the Legislature.

~~SEC. 20.~~

SEC. 49. Section 5701.2 of the Welfare and Institutions Code is amended to read:

5701.2. (a) The State Department of Mental Health, or its successor, the State Department of State Hospitals, shall maintain records of any transfer of funds or state hospital beds made pursuant to Chapter 1341 of the Statutes of 1991.

(b) Commencing with the 1991–92 fiscal year, the State Department of Mental Health, or its successor, the State Department of State Hospitals, shall maintain records that set forth that portion of each county's allocation of state mental health moneys that represent the dollar equivalent attributed to each county's state hospital beds or bed days, or both, that were allocated as of May 1, 1991. The State Department of Mental Health, or its successor, the State Department of State Hospitals, shall provide a written summary of these records to the appropriate committees of the Legislature and the County Behavioral Health Directors Association of California within 30 days after the enactment of the annual Budget Act.

(c) Nothing in this section is intended to change the counties' base allocations as provided in subdivisions (a) and (b) of Section 17601.

~~SEC. 21.~~

SEC. 50. Section 5717 of the Welfare and Institutions Code is amended to read:

5717. (a) Expenditures that may be funded from amounts allocated to the county by the State Department of Health Care Services from funds appropriated to the department shall include, salaries of personnel, approved facilities and services provided through contract, and operation, maintenance, and service costs, including insurance costs or departmental charges for participation in a county self-insurance program if the charges are not in excess of comparable available commercial insurance premiums and on the condition that any surplus reserves be used to reduce future year contributions; depreciation of county facilities as established in the state's uniform accounting manual, disregarding depreciation on the facility to the extent it was financed by state funds under this part; lease of facilities where there is no intention to, nor option to, purchase; expenses incurred under this act by members of the County Behavioral Health Directors Association of California for

attendance at regular meetings of these conferences; expenses incurred by either the chairperson or elected representative of the local mental health advisory boards for attendance at regular meetings of the ~~Organization of Mental Health Advisory Boards;~~ *organization of mental health advisory boards;* expenditures included in approved countywide cost allocation plans submitted in accordance with the Controller's guidelines, including, but not limited to, adjustments of prior year estimated general county overhead to actual costs, but excluding allowable costs otherwise compensated by state funding; net costs of conservatorship investigation, approved by the Director of Health Care Services. Except for expenditures made pursuant to Article 6 (commencing with Section 129225) of Chapter 1 of Part 6 of Division 107 of the Health and Safety Code, it shall not include expenditures for initial capital improvements; the purchaser or construction of buildings except for equipment items and remodeling expense as may be provided for in regulations of the State Department of Health Care Services; compensation to members of a local mental health advisory board, except actual and necessary expenses incurred in the performance of official duties that may include travel, lodging, and meals while on official business; or expenditures for a purpose for which state reimbursement is claimed under any other provision of law.

(b) The Director of Health Care Services may make investigations and audits of expenditures the director may deem necessary.

(c) With respect to funds allocated to a county by the State Department of Health Care Services from funds appropriated to the department, the county shall repay to the state amounts found not to have been expended in accordance with the requirements set forth in this part. Repayment shall be within 30 days after it is determined that an expenditure has been made that is not in accordance with the requirements. In the event that repayment is not made in a timely manner, the department shall offset any amount improperly expended against the amount of any current or future advance payment or cost report settlement from the state for mental health services. Repayment provisions shall not apply to Short-Doyle funds allocated by the department for fiscal years up to and including the 1990–91 fiscal year.

~~SEC. 22.~~

SEC. 51. Section 5750 of the Welfare and Institutions Code is amended to read:

5750. The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the County Behavioral Health Directors Association of California and the California Mental Health Planning Council.

SEC. 52. Section 5814.5 of the Welfare and Institutions Code is amended to read:

5814.5. (a) (1) In any year in which funds are appropriated for this purpose through the annual Budget Act, counties funded under this part in the 1999–2000 fiscal year are eligible for funding to continue their programs if they have successfully demonstrated the effectiveness of their grants received in that year and to expand their programs if they also demonstrate significant continued unmet need and capacity for expansion without compromising quality or effectiveness of care.

(2) In any year in which funds are appropriated for this purpose through the annual Budget Act, other counties or portions of counties, or cities that operate independent public mental health programs pursuant to Section 5615 of the Welfare and Institutions Code, are eligible for funding to establish programs if a county or eligible city demonstrates that it can provide comprehensive services, as set forth in this part, to a substantial number of adults who are severely mentally ill, as defined in Section 5600.3, and are homeless or recently released from the county jail or who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided.

(b) (1) Counties eligible for funding pursuant to subdivision (a) shall be those that have or can develop integrated adult service programs that meet the criteria for an adult system of care, as set forth in Section 5806, and that have, or can develop, integrated forensic programs with similar characteristics for parolees and those recently released from county jail who meet the target population requirements of Section 5600.3 and are at risk of incarceration unless the services are provided. Before a city or county submits a proposal to the state to establish or expand a

program, the proposal shall be reviewed by a local advisory committee or mental health board, which may be an existing body, that includes clients, family members, private providers of services, and other relevant stakeholders. Local enrollment for integrated adult service programs and for integrated forensic programs funded pursuant to subdivision (a) shall adhere to all conditions set forth by the department, including the total number of clients to be enrolled, the providers to which clients are enrolled and the maximum cost for each provider, the maximum number of clients to be served at any one time, the outreach and screening process used to identify enrollees, and the total cost of the program. Local enrollment of each individual for integrated forensic programs shall be subject to the approval of the county ~~mental~~ *behavioral* health director or his or her designee.

(2) Each county shall ensure that funds provided by these grants are used to expand existing integrated service programs that meet the criteria of the adult system of care to provide new services in accordance with the purpose for which they were appropriated and allocated, and that none of these funds shall be used to supplant existing services to severely mentally ill adults. In order to ensure that this requirement is met, the department shall develop methods and contractual requirements, as it determines necessary. At a minimum, these assurances shall include that state and federal requirements regarding tracking of funds are met and that patient records are maintained in a manner that protects privacy and confidentiality, as required under federal and state law.

(c) Each county selected to receive a grant pursuant to this section shall provide data as the department may require, that demonstrates the outcomes of the adult system of care programs, shall specify the additional numbers of severely mentally ill adults to whom they will provide comprehensive services for each million dollars of additional funding that may be awarded through either an integrated adult service grant or an integrated forensic grant, and shall agree to provide services in accordance with Section 5806. Each county's plan shall identify and include sufficient funding to provide housing for the individuals to be served, and shall ensure that any hospitalization of individuals participating in the program are coordinated with the provision of other mental health services provided under the program.

~~SEC. 23.~~

SEC. 53. Section 5845 of the Welfare and Institutions Code is amended to read:

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another ~~member~~ *Member* of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees, such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), *Part* 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section ~~5800),~~ *5800)* and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California.

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

~~SEC. 24.~~

SEC. 54. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county ~~mental~~ *behavioral* health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county ~~mental~~ *behavioral* health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are

consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ~~ages 16 to 25.~~ *16 to 25 years of age.* In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

~~SEC. 25.~~

SEC. 55. Section 5848 of the Welfare and Institutions Code is amended to read:

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans,

representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section ~~5800),~~ *5800)* and Part 4 (commencing with Section ~~5850),~~ *5850)* shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

~~SEC. 26.~~

SEC. 56. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective outpatient and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric ~~evacuation~~ *evaluation* can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and

collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis

stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that ~~includes,~~ *include,* but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating the local service sector to improve efficiencies and the delivery of services.

(1) Triage personnel may provide targeted case management services face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for triage personnel as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel and use of peer support.

(C) Description of how triage personnel will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or city mental health department that receives an award of funds for the purpose of supporting triage personnel pursuant to this subdivision is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or

make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2014.

~~SEC. 27.~~

SEC. 57. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in ~~2007–08~~ *2007–08,* 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, ~~2006–07~~ *2006–07,* and in ~~2007–08~~ *2007–08,* 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section ~~5850),~~ *5850)* for the children's system of care and Part 3 (commencing with Section ~~5800),~~ *5800)* for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section ~~5800),~~ *5800)* and Part 4

(commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section ~~5800),~~ *5800)* and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In ~~2004–05~~ *2004–05,* funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and

mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for ~~fiscal year 2011–12.~~ *the 2011–12 fiscal year.* These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in ~~fiscal year~~ *the* 2011–12 *fiscal year* that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(*l*) Subdivision (j) shall become inoperative on July 1, 2012.

~~SEC. 28.~~

SEC. 58. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.
(2) Prevention and early intervention strategies.
(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

~~SEC. 29.~~

SEC. 59. Section 5902 of the Welfare and Institutions Code is amended to read:

5902. (a) In the 1991–92 fiscal year, funding sufficient to cover the cost of the basic level of care in institutions for mental disease at the rate established by the State Department of Health *Care* Services shall be made available to the department for skilled nursing facilities, plus the rate established for special treatment programs. The department may authorize a county to administer institutions for mental disease services if the county with the consent of the affected providers makes a request to administer services and an allocation is made to the county for these services. The department shall continue to contract with these providers for the services necessary for the operation of the institutions for mental disease.

(b) In the 1992–93 fiscal year, the department shall consider county-specific requests to continue to provide administrative services relative to institutions for mental disease facilities when no viable alternatives are found to exist.

(c) (1) By October 1, 1991, the department, in consultation with the County Behavioral Health Directors Association of California and the California Association of Health Facilities, shall develop and publish a county-specific allocation of institutions for mental disease funds that will take effect on July 1, 1992.

(2) By November 1, 1991, counties shall notify the providers of any intended change in service levels to be effective on July 1, 1992.

(3) By April 1, 1992, counties and providers shall have entered into contracts for basic institutions for mental disease services at the rate described in subdivision (e) for the 1992–93 fiscal year at the level expressed on or before November 1, 1991, except that a county shall be permitted additional time, until June 1, 1992, to complete the processing of the contract, when any of the following conditions are met:

(A) The county and the affected provider have agreed on all substantive institutions for mental disease contract issues by April 1, 1992.

(B) Negotiations are in process with the county on April 1, 1992, and the affected provider has agreed in writing to the extension.

(C) The service level committed to on November 1, 1991, exceeds the affected provider's bed capacity.

(D) The county can document that the affected provider has refused to enter into negotiations by April 1, 1992, or has substantially delayed negotiations.

(4) If a county and a provider are unable to reach agreement on substantive contract issues by June 1, 1992, the department may, upon request of either the affected county or the provider, mediate the disputed issues.

(5) ~~Where~~ *When* contracts for service at the level committed to on November 1, 1991, have not been completed by April 1, 1992, and additional time is not permitted pursuant to the exceptions specified in paragraph (3) the funds allocated to those counties shall revert for reallocation in a manner that shall promote equity of funding among counties. With respect to counties with exceptions permitted pursuant to paragraph (3), funds shall not revert unless contracts are not completed by June 1, 1992. In no event shall funds revert under this section if there is no harm to the provider as a result of the county contract not being completed. During the 1992–93 fiscal year, funds reverted under this paragraph shall be used to purchase institution for mental disease/skilled nursing/special treatment program services in existing facilities.

(6) Nothing in this section shall apply to negotiations regarding supplemental payments beyond the rate specified in subdivision (e).

(d) On or before April 1, 1992, counties may complete contracts with facilities for the direct purchase of services in the 1992–93 fiscal year. Those counties for which facility contracts have not been completed by that date shall be deemed to continue to accept financial responsibility for those patients during the subsequent fiscal year at the rate specified in subdivision (a).

(e) As long as contracts with institutions for mental disease providers require the facilities to maintain skilled nursing facility licensure and certification, reimbursement for basic services shall be at the rate established by the State Department of Health *Care*

Services. Except as provided in this section, reimbursement rates for services in institutions for mental diseases shall be the same as the rates in effect on July 31, 2004. Effective July 1, 2005, through June 30, 2008, the reimbursement rate for institutions for mental disease shall increase by 6.5 percent annually. Effective July 1, 2008, the reimbursement rate for institutions for mental disease shall increase by 4.7 percent annually.

(f) (1) Providers that agree to contract with the county for services under an alternative mental health program pursuant to Section 5768 that does not require skilled nursing facility licensure shall retain return rights to licensure as skilled nursing facilities.

(2) Providers participating in an alternative program that elect to return to skilled nursing facility licensure shall only be required to meet those requirements under which they previously operated as a skilled nursing facility.

(g) In the 1993–94 fiscal year and thereafter, the department shall consider requests to continue administrative services related to institutions for mental disease facilities from counties with a population of 150,000 or less based on the most recent available estimates of population data as determined by the Population Research Unit of the Department of Finance.

SEC. 60. Section 6002.25 of the Welfare and Institutions Code is amended to read:

6002.25. The independent clinical review shall be conducted by a licensed psychiatrist with training and experience in treating psychiatric adolescent patients, who is a neutral party to the review, having no direct financial relationship with the treating clinician, nor a personal or financial relationship with the patient, or his or her parents or guardian. Nothing in this section shall prevent a psychiatrist affiliated with a health maintenance organization, as defined in subdivision (b) of Section 1373.10 of the Health and Safety Code, from providing the independent clinical review where the admitting, treating, and reviewing psychiatrists are affiliated with a health maintenance organization that predominantly serves members of a prepaid health care service plan. The independent clinical reviewer shall be assigned, on a rotating basis, from a list prepared by the facility, and submitted to the county ~~mental~~ *behavioral* health director prior to March 1, 1990, and annually thereafter, or more frequently when necessary. The county ~~mental~~ *behavioral* health director shall, on an annual basis, or at the

request of the facility, review the facility's list of independent clinical reviewers. The county ~~mental~~ *behavioral* health director shall approve or disapprove the list of reviewers within 30 days of submission. If there is no response from the county ~~mental~~ *behavioral* health director, the facility's list shall be deemed approved. If the county ~~mental~~ *behavioral* health director disapproves one or more of the persons on the list of reviewers, the county ~~mental~~ *behavioral* health director shall notify the facility in writing of the reasons for the disapproval. The county ~~mental~~ *behavioral* health director, in consultation with the facility, may develop a list of one or more additional reviewers within 30 days. The final list shall be mutually agreeable to the county ~~mental~~ *behavioral* health director and the facility. Sections 6002.10 to 6002.40, inclusive, shall not be construed to prohibit the treatment of minors prior to the existence of an approved list of independent clinical reviewers. The independent clinical reviewer may be an active member of the medical staff of the facility who has no direct financial relationship, including, but not limited to, an employment or other contract arrangement with the facility except for compensation received for the service of providing clinical reviews.

SEC. 61. Section 8103 of the Welfare and Institutions Code is amended to read:

8103. (a) (1) No person who after October 1, 1955, has been adjudicated by a court of any state to be a danger to others as a result of a mental disorder or mental illness, or who has been adjudicated to be a mentally disordered sex offender, shall purchase or receive, or attempt to purchase or receive, or have in his or her possession, custody, or control a firearm or any other deadly weapon unless there has been issued to the person a certificate by the court of adjudication upon release from treatment or at a later date stating that the person may possess a firearm or any other deadly weapon without endangering others, and the person has not, subsequent to the issuance of the certificate, again been adjudicated by a court to be a danger to others as a result of a mental disorder or mental illness.

(2) The court shall notify the Department of Justice of the court order finding the individual to be a person described in paragraph (1) as soon as possible, but not later than one court day after issuing the order. The court shall also notify the Department of Justice of any certificate issued as described in paragraph (1) as soon as

possible, but not later than one court day after issuing the certificate.

(b) (1) No person who has been found, pursuant to Section 1026 of the Penal Code or the law of any other state or the United States, not guilty by reason of insanity of murder, mayhem, a violation of Section 207, 209, or 209.5 of the Penal Code in which the victim suffers intentionally inflicted great bodily injury, carjacking or robbery in which the victim suffers great bodily injury, a violation of Section 451 or 452 of the Penal Code involving a trailer coach, as defined in Section 635 of the Vehicle Code, or any dwelling house, a violation of paragraph (1) or (2) of subdivision (a) of Section 262 or paragraph (2) or (3) of subdivision (a) of Section 261 of the Penal Code, a violation of Section 459 of the Penal Code in the first degree, assault with intent to commit murder, a violation of Section 220 of the Penal Code in which the victim suffers great bodily injury, a violation of Section 18715, 18725, 18740, 18745, 18750, or 18755 of the Penal Code, or of a felony involving death, great bodily injury, or an act which poses a serious threat of bodily harm to another person, or a violation of the law of any other state or the United States that includes all the elements of any of the above felonies as defined under California law, shall purchase or receive, or attempt to purchase or receive, or have in his or her possession or under his or her custody or control any firearm or any other deadly weapon.

(2) The court shall notify the Department of Justice of the court order finding the person to be a person described in paragraph (1) as soon as possible, but not later than, one court day after issuing the order.

(c) (1) No person who has been found, pursuant to Section 1026 of the Penal Code or the law of any other state or the United States, not guilty by reason of insanity of any crime other than those described in subdivision (b) shall purchase or receive, or attempt to purchase or receive, or shall have in his or her possession, custody, or control any firearm or any other deadly weapon unless the court of commitment has found the person to have recovered sanity, pursuant to Section 1026.2 of the Penal Code or the law of any other state or the United States.

(2) The court shall notify the Department of Justice of the court order finding the person to be a person described in paragraph (1)

as soon as possible, but not later than one court day after issuing the order. The court shall also notify the Department of Justice when it finds that the person has recovered his or her sanity as soon as possible, but not later than one court day after making the finding.

(d) (1) No person found by a court to be mentally incompetent to stand trial, pursuant to Section 1370 or 1370.1 of the Penal Code or the law of any other state or the United States, shall purchase or receive, or attempt to purchase or receive, or shall have in his or her possession, custody, or control, any firearm or any other deadly weapon, unless there has been a finding with respect to the person of restoration to competence to stand trial by the committing court, pursuant to Section 1372 of the Penal Code or the law of any other state or the United States.

(2) The court shall notify the Department of Justice of the court order finding the person to be mentally incompetent as described in paragraph (1) as soon as possible, but not later than one court day after issuing the order. The court shall also notify the Department of Justice when it finds that the person has recovered his or her competence as soon as possible, but not later than one court day after making the finding.

(e) (1) No person who has been placed under conservatorship by a court, pursuant to Section 5350 or the law of any other state or the United States, because the person is gravely disabled as a result of a mental disorder or impairment by chronic alcoholism, shall purchase or receive, or attempt to purchase or receive, or shall have in his or her possession, custody, or control, any firearm or any other deadly weapon while under the conservatorship if, at the time the conservatorship was ordered or thereafter, the court that imposed the conservatorship found that possession of a firearm or any other deadly weapon by the person would present a danger to the safety of the person or to others. Upon placing a person under conservatorship, and prohibiting firearm or any other deadly weapon possession by the person, the court shall notify the person of this prohibition.

(2) The court shall notify the Department of Justice of the court order placing the person under conservatorship and prohibiting firearm or any other deadly weapon possession by the person as described in paragraph (1) as soon as possible, but not later than one court day after placing the person under conservatorship. The

notice shall include the date the conservatorship was imposed and the date the conservatorship is to be terminated. If the conservatorship is subsequently terminated before the date listed in the notice to the Department of Justice or the court subsequently finds that possession of a firearm or any other deadly weapon by the person would no longer present a danger to the safety of the person or others, the court shall notify the Department of Justice as soon as possible, but not later than one court day after terminating the conservatorship.

(3) All information provided to the Department of Justice pursuant to paragraph (2) shall be kept confidential, separate, and apart from all other records maintained by the Department of Justice, and shall be used only to determine eligibility to purchase or possess firearms or other deadly weapons. A person who knowingly furnishes that information for any other purpose is guilty of a misdemeanor. All the information concerning any person shall be destroyed upon receipt by the Department of Justice of notice of the termination of conservatorship as to that person pursuant to paragraph (2).

(f) (1) No person who has been (A) taken into custody as provided in Section 5150 because that person is a danger to himself, herself, or to others, (B) assessed within the meaning of Section 5151, and (C) admitted to a designated facility within the meaning of Sections 5151 and 5152 because that person is a danger to himself, herself, or others, shall own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase any firearm for a period of five years after the person is released from the facility. A person described in the preceding sentence, however, may own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase any firearm if the superior court has, pursuant to paragraph (5), found that the people of the State of California have not met their burden pursuant to paragraph (6).

(2) (A) For each person subject to this subdivision, the facility shall, within 24 hours of the time of admission, submit a report to the Department of Justice, on a form prescribed by the Department of Justice, containing information that includes, but is not limited to, the identity of the person and the legal grounds upon which the person was admitted to the facility.

Any report submitted pursuant to this paragraph shall be confidential, except for purposes of the court proceedings described in this subdivision and for determining the eligibility of the person to own, possess, control, receive, or purchase a firearm.

(B) Commencing July 1, 2012, facilities shall submit reports pursuant to this paragraph exclusively by electronic means, in a manner prescribed by the Department of Justice.

(3) Prior to, or concurrent with, the discharge, the facility shall inform a person subject to this subdivision that he or she is prohibited from owning, possessing, controlling, receiving, or purchasing any firearm for a period of five years. Simultaneously, the facility shall inform the person that he or she may request a hearing from a court, as provided in this subdivision, for an order permitting the person to own, possess, control, receive, or purchase a firearm. The facility shall provide the person with a form for a request for a hearing. The Department of Justice shall prescribe the form. Where the person requests a hearing at the time of discharge, the facility shall forward the form to the superior court unless the person states that he or she will submit the form to the superior court.

(4) The Department of Justice shall provide the form upon request to any person described in paragraph (1). The Department of Justice shall also provide the form to the superior court in each county. A person described in paragraph (1) may make a single request for a hearing at any time during the five-year period. The request for hearing shall be made on the form prescribed by the department or in a document that includes equivalent language.

(5) A person who is subject to paragraph (1) who has requested a hearing from the superior court of his or her county of residence for an order that he or she may own, possess, control, receive, or purchase firearms shall be given a hearing. The clerk of the court shall set a hearing date and notify the person, the Department of Justice, and the district attorney. The people of the State of California shall be the plaintiff in the proceeding and shall be represented by the district attorney. Upon motion of the district attorney, or on its own motion, the superior court may transfer the hearing to the county in which the person resided at the time of his or her detention, the county in which the person was detained, or the county in which the person was evaluated or treated. Within seven days after the request for a hearing, the Department of Justice

shall file copies of the reports described in this section with the superior court. The reports shall be disclosed upon request to the person and to the district attorney. The court shall set the hearing within 30 days of receipt of the request for a hearing. Upon showing good cause, the district attorney shall be entitled to a continuance not to exceed 14 days after the district attorney was notified of the hearing date by the clerk of the court. If additional continuances are granted, the total length of time for continuances shall not exceed 60 days. The district attorney may notify the county ~~mental~~ *behavioral* health director of the hearing who shall provide information about the detention of the person that may be relevant to the court and shall file that information with the superior court. That information shall be disclosed to the person and to the district attorney. The court, upon motion of the person subject to paragraph (1) establishing that confidential information is likely to be discussed during the hearing that would cause harm to the person, shall conduct the hearing in camera with only the relevant parties present, unless the court finds that the public interest would be better served by conducting the hearing in public. Notwithstanding any other law, declarations, police reports, including criminal history information, and any other material and relevant evidence that is not excluded under Section 352 of the Evidence Code shall be admissible at the hearing under this section.

(6) The people shall bear the burden of showing by a preponderance of the evidence that the person would not be likely to use firearms in a safe and lawful manner.

(7) If the court finds at the hearing set forth in paragraph (5) that the people have not met their burden as set forth in paragraph (6), the court shall order that the person shall not be subject to the five-year prohibition in this section on the ownership, control, receipt, possession, or purchase of firearms, and that person shall comply with the procedure described in Chapter 2 (commencing with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal Code for the return of any firearms. A copy of the order shall be submitted to the Department of Justice. Upon receipt of the order, the Department of Justice shall delete any reference to the prohibition against firearms from the person's state mental health firearms prohibition system information.

(8) Where the district attorney declines or fails to go forward in the hearing, the court shall order that the person shall not be

subject to the five-year prohibition required by this subdivision on the ownership, control, receipt, possession, or purchase of firearms. A copy of the order shall be submitted to the Department of Justice. Upon receipt of the order, the Department of Justice shall, within 15 days, delete any reference to the prohibition against firearms from the person's state mental health firearms prohibition system information, and that person shall comply with the procedure described in Chapter 2 (commencing with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal Code for the return of any firearms.

(9) Nothing in this subdivision shall prohibit the use of reports filed pursuant to this section to determine the eligibility of persons to own, possess, control, receive, or purchase a firearm if the person is the subject of a criminal investigation, a part of which involves the ownership, possession, control, receipt, or purchase of a firearm.

(g) (1) No person who has been certified for intensive treatment under Section 5250, 5260, or 5270.15 shall own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase, any firearm for a period of five years.

Any person who meets the criteria contained in subdivision (e) or (f) who is released from intensive treatment shall nevertheless, if applicable, remain subject to the prohibition contained in subdivision (e) or (f).

(2) (A) For each person certified for intensive treatment under paragraph (1), the facility shall, within 24 hours of the certification, submit a report to the Department of Justice, on a form prescribed by the department, containing information regarding the person, including, but not limited to, the legal identity of the person and the legal grounds upon which the person was certified. A report submitted pursuant to this paragraph shall only be used for the purposes specified in paragraph (2) of subdivision (f).

(B) Commencing July 1, 2012, facilities shall submit reports pursuant to this paragraph exclusively by electronic means, in a manner prescribed by the Department of Justice.

(3) Prior to, or concurrent with, the discharge of each person certified for intensive treatment under paragraph (1), the facility shall inform the person of that information specified in paragraph (3) of subdivision (f).

(4) A person who is subject to paragraph (1) may petition the superior court of his or her county of residence for an order that he or she may own, possess, control, receive, or purchase firearms. At the time the petition is filed, the clerk of the court shall set a hearing date and notify the person, the Department of Justice, and the district attorney. The people of the State of California shall be the respondent in the proceeding and shall be represented by the district attorney. Upon motion of the district attorney, or on its own motion, the superior court may transfer the petition to the county in which the person resided at the time of his or her detention, the county in which the person was detained, or the county in which the person was evaluated or treated. Within seven days after receiving notice of the petition, the Department of Justice shall file copies of the reports described in this section with the superior court. The reports shall be disclosed upon request to the person and to the district attorney. The district attorney shall be entitled to a continuance of the hearing to a date of not less than 14 days after the district attorney was notified of the hearing date by the clerk of the court. The district attorney may notify the county ~~mental~~ *behavioral* health director of the petition, and the county ~~mental~~ *behavioral* health director shall provide information about the detention of the person that may be relevant to the court and shall file that information with the superior court. That information shall be disclosed to the person and to the district attorney. The court, upon motion of the person subject to paragraph (1) establishing that confidential information is likely to be discussed during the hearing that would cause harm to the person, shall conduct the hearing in camera with only the relevant parties present, unless the court finds that the public interest would be better served by conducting the hearing in public. Notwithstanding any other law, any declaration, police reports, including criminal history information, and any other material and relevant evidence that is not excluded under Section 352 of the Evidence Code, shall be admissible at the hearing under this section. If the court finds by a preponderance of the evidence that the person would be likely to use firearms in a safe and lawful manner, the court may order that the person may own, control, receive, possess, or purchase firearms, and that person shall comply with the procedure described in Chapter 2 (commencing with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal Code for the return of any firearms.

A copy of the order shall be submitted to the Department of Justice. Upon receipt of the order, the Department of Justice shall delete any reference to the prohibition against firearms from the person's state mental health firearms prohibition system information.

(h) (1) For all persons identified in subdivisions (f) and (g), facilities shall report to the Department of Justice as specified in those subdivisions, except facilities shall not report persons under subdivision (g) if the same persons previously have been reported under subdivision (f).

(2) Additionally, all facilities shall report to the Department of Justice upon the discharge of persons from whom reports have been submitted pursuant to subdivision (f) or (g). However, a report shall not be filed for persons who are discharged within 31 days after the date of admission.

(i) Every person who owns or possesses or has under his or her custody or control, or purchases or receives, or attempts to purchase or receive, any firearm or any other deadly weapon in violation of this section shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code or in a county jail for not more than one year.

(j) "Deadly weapon," as used in this section, has the meaning prescribed by Section 8100.

(k) Any notice or report required to be submitted to the Department of Justice pursuant to this section shall be submitted in an electronic format, in a manner prescribed by the Department of Justice.

~~SEC. 30.~~

SEC. 62. Section 11467 of the Welfare and Institutions Code is amended to read:

11467. (a) The State Department of Social Services, with the advice and assistance of the County Welfare Directors ~~Association,~~ *Association of California*, the Chief Probation ~~Officer's Association,~~ *Officers of California*, the County Behavioral Health Directors Association of California, research entities, foster youth and advocates for foster youth, foster care provider business entities organized and operated on a nonprofit basis, tribes, and other stakeholders, shall establish a working group to develop performance standards and outcome measures for providers of out-of-home care placements made under the AFDC-FC program, including, but not limited to, foster family agency, group home,

and THP-Plus providers, and for the effective and efficient administration of the AFDC-FC program.

(b) The performance standards and outcome measures shall employ the applicable performance standards and outcome measures as set forth in Sections 11469 and 11469.1, designed to identify the degree to which foster care providers, including business entities organized and operated on a nonprofit basis, are providing out-of-home placement services that meet the needs of foster children, and the degree to which these services are supporting improved outcomes, including those identified by the California Child and Family Service Review System.

(c) In addition to the process described in subdivision (a), the working group may also develop the following:

(1) A means of identifying the child's needs and determining which is the most appropriate out-of-home placement for a child.

(2) A procedure for identifying children who have been in congregate care for one year or longer, determining the reasons each child remains in congregate care, and developing a plan for each child to transition to a less restrictive, more family-like setting.

(d) The department shall provide updates regarding its progress toward meeting the requirements of this section during the 2013 and 2014 budget hearings.

(e) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 13340) of Part 1 of Division 3 of Title 2 of the Government Code), until the enactment of applicable state law, or October 1, 2015, whichever is earlier, the department may implement the changes made pursuant to this section through all-county letters, or similar instructions from the director.

~~SEC. 31.~~

SEC. 63. Section 11469 of the Welfare and Institutions Code is amended to read:

11469. (a) The department, in consultation with group home providers, the County Welfare Directors ~~Association,~~ *Association of California*, the Chief Probation Officers of California, the County Behavioral Health Directors Association of California, and the State Department of Health Care Services, shall develop performance standards and outcome measures for determining the effectiveness of the care and supervision, as defined in subdivision (b) of Section 11460, provided by group homes under the

AFDC-FC program pursuant to Sections 11460 and 11462. These standards shall be designed to measure group home program performance for the client group that the group home program is designed to serve.

(1) The performance standards and outcome measures shall be designed to measure the performance of group home programs in areas over which the programs have some degree of influence, and in other areas of measurable program performance that the department can demonstrate are areas over which group home programs have meaningful managerial or administrative influence.

(2) These standards and outcome measures shall include, but are not limited to, the effectiveness of services provided by each group home program, and the extent to which the services provided by the group home assist in obtaining the child welfare case plan objectives for the child.

(3) In addition, when the group home provider has identified as part of its program for licensing, ratesetting, or county placement purposes, or has included as a part of a child's case plan by mutual agreement between the group home and the placing agency, specific mental health, education, medical, and other child-related services, the performance standards and outcome measures may also measure the effectiveness of those services.

(b) Regulations regarding the implementation of the group home performance standards system required by this section shall be adopted no later than one year prior to implementation. The regulations shall specify both the performance standards system and the manner by which the AFDC-FC rate of a group home program shall be adjusted if performance standards are not met.

(c) Except as provided in subdivision (d), effective July 1, 1995, group home performance standards shall be implemented. Any group home program not meeting the performance standards shall have its AFDC-FC rate, set pursuant to Section 11462, adjusted according to the regulations required by this section.

(d) Effective July 1, 1995, group home programs shall be classified at rate classification level 13 or 14 only if all of the following are met:

(1) The program generates the requisite number of points for rate classification level 13 or 14.

(2) The program only accepts children with special treatment needs as determined through the assessment process pursuant to paragraph (2) of subdivision (a) of Section 11462.01.

(3) The program meets the performance standards designed pursuant to this section.

(e) Notwithstanding subdivision (c), the group home program performance standards system shall not be implemented prior to the implementation of the AFDC-FC performance standards system.

(f) By January 1, 2016, the department, in consultation with the County Welfare Directors ~~Association,~~ *Association of California*, the Chief Probation Officers of California, the County Behavioral Health Directors Association of California, research entities, foster youth and advocates for foster youth, foster care provider business entities organized and operated on a nonprofit basis, Indian tribes, and other stakeholders, shall develop additional performance standards and outcome measures that require group homes to implement programs and services to minimize law enforcement contacts and delinquency petition filings arising from incidents of allegedly unlawful behavior by minors occurring in group homes or under the supervision of group home staff, including individualized behavior management programs, emergency intervention plans, and conflict resolution processes.

~~SEC. 32.~~

SEC. 64. Section 14021.4 of the Welfare and Institutions Code is amended to read:

14021.4. (a) California's plan for federal Medi-Cal grants for medical assistance programs, pursuant to Subchapter XIX (commencing with Section 1396) of Title 42 of the United States Code, shall accomplish the following objectives:

(1) Expansion of the location and type of therapeutic services offered to persons with mental illnesses under Medi-Cal by the category of "other diagnostic, screening, preventative, and rehabilitative services" that is available to states under the federal Social Security Act and its implementing regulations (42 U.S.C. Sec. 1396d(a)(13); 42 C.F.R. 440.130).

(2) Expansion of federal financial participation in the costs of specialty mental health services provided by local mental health plans or under contract with the mental health plans.

(3) Expansion of the location where reimbursable specialty mental health services can be provided, including home, school, and ~~community based~~ *community-based* sites.

(4) Expansion of federal financial participation for services that meet the rehabilitation needs of persons with mental illnesses, including, but not limited to, medication management, functional rehabilitation assessments of clients, and rehabilitative services that include remedial services directed at restoration to the highest possible functional level for persons with mental illnesses and maximum reduction of symptoms of mental illness.

(5) Improvement of fiscal systems and accountability structures for specialty mental health services, costs, and rates, with the goal of achieving federal fiscal requirements.

(b) The department's state plan revision shall be completed with review and comments by the County Behavioral Health Directors Association of California and other appropriate groups.

(c) Services under the rehabilitative option shall be limited to specialty mental health plans certified to provide Medi-Cal under this option.

(d) It is the intent of the Legislature that the rehabilitation option of the state Medicaid plan be implemented to expand and provide flexibility to treatment services and to increase the federal participation without increasing the costs to the General Fund.

(e) The department shall review and revise the quality assurance standards and guidelines required by Section 14725 to ensure that quality services are delivered to the eligible population. Any reviews shall include, but not be limited to, appropriate use of mental health professionals, including psychiatrists, in the treatment and rehabilitation of clients under this model. The existing quality assurance standards and guidelines shall remain in effect until the adoption of the new quality assurance standards and guidelines.

(f) Consistent with services offered to persons with mental illnesses under the Medi-Cal program, as required by this section, it is the intent of the Legislature for the department to include care and treatment of persons with mental illnesses who are eligible for the Medi-Cal program in facilities with a bed capacity of 16 beds or less.

~~SEC. 33.~~

SEC. 65. Section 14124.24 of the Welfare and Institutions Code is amended to read:

14124.24. (a) For purposes of this section, "Drug Medi-Cal reimbursable services" means the substance use disorder services described in the California ~~State Medicaid~~ *Medicaid State* Plan and includes, but is not limited to, all of the following services, administered by the department, and to the extent consistent with state and federal law:

(1) Narcotic treatment program services, as set forth in Section 14021.51.

(2) Day care rehabilitative services.

(3) Perinatal residential services for pregnant women and women in the postpartum period.

(4) Naltrexone services.

(5) Outpatient drug-free services.

(6) Other services upon approval of a federal Medicaid state plan amendment or waiver authorizing federal financial participation.

(b) (1) While seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Drug Medi-Cal services, the department shall consult with the counties and stakeholders in the development of the state plan amendment or waiver.

(2) Upon federal approval of a federal Medicaid state plan amendment authorizing federal financial participation in the following services, and subject to appropriation of funds, "Drug Medi-Cal reimbursable services" shall also include the following services, administered by the department, and to the extent consistent with state and federal law:

(A) Notwithstanding subdivision (a) of Section 14132.90, day care habilitative services, which, for purposes of this paragraph, are outpatient counseling and rehabilitation services provided to persons with substance use disorder diagnoses.

(B) Case management services, including supportive services to assist persons with substance use disorder diagnoses in gaining access to medical, social, educational, and other needed services.

(C) Aftercare services.

(c) (1) The nonfederal share for Drug Medi-Cal services shall be funded through a county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011, and any other available county funds eligible under federal law for federal Medicaid reimbursement. The funds contained in each

county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011 shall be considered state funds distributed by the principal state agency for the purposes of receipt of the federal block grant funds for prevention and treatment of substance abuse found at Subchapter XVII of Chapter 6A of Title 42 of the United States Code. Pursuant to applicable federal Medicaid law and regulations including Section 433.51 of Title 42 of the Code of Federal Regulations, counties may claim allowable Medicaid federal financial participation for Drug Medi-Cal services based on the counties certifying their actual total funds expenditures for eligible Drug Medi-Cal services to the department.

(2) (A) If the director determines that a county's provision of Drug Medi-Cal treatment services are disallowed by the federal government or by state or federal audit or review, the impacted county shall be responsible for repayment of all disallowed federal funds. In addition to any other recovery methods available, including, but not limited to, offset of Medicaid federal financial participation funds owed to the impacted county, the director may offset these amounts in accordance with Section 12419.5 of the Government Code.

(B) A county subject to an action by the director pursuant to subparagraph (A) may challenge that action by requesting a hearing in writing no later than 30 days from receipt of notice of the department's action. The proceeding shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director has all the powers granted therein. Upon a county's timely request for hearing, the county's obligation to make payment as determined by the director shall be stayed pending the county's exhaustion of administrative remedies provided herein but no longer than will ensure the department's compliance with Section 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396b).

(d) Drug Medi-Cal services are only reimbursable to Drug Medi-Cal providers with an approved Drug Medi-Cal contract.

(e) Counties shall negotiate contracts only with providers certified to provide Drug Medi-Cal services.

(f) The department shall develop methods to ensure timely payment of Drug Medi-Cal claims.

(g) (1) A county or a contracted provider, except for a provider to whom subdivision (h) applies, shall submit accurate and complete cost reports for the previous fiscal year by November 1, following the end of the fiscal year. The department may settle Drug Medi-Cal reimbursable services, based on the cost report as the final amendment to the approved county Drug Medi-Cal contract.

(2) Amounts paid for services provided to Drug Medi-Cal beneficiaries shall be audited by the department in the manner and form described in Section 14170.

(3) Administrative appeals to review grievances or complaints arising from the findings of an audit or examination made pursuant to this section shall be subject to Section 14171.

(h) Certified narcotic treatment program providers that are exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 of this code shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. A provider to which this subdivision applies shall estimate its budgets using the uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Behavioral Health Directors Association of California, and representatives of the treatment providers.

(i) Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(j) Annually, the department shall publish procedures for contracting for Drug Medi-Cal services with certified providers and for claiming payments, including procedures and specifications for electronic data submission for services rendered.

(k) If the department commences a preliminary criminal investigation of a certified provider, the department shall promptly notify each county that currently contracts with the provider for Drug Medi-Cal services that a preliminary criminal investigation has commenced. If the department concludes a preliminary criminal investigation of a certified provider, the department shall promptly notify each county that currently contracts with the provider for

Drug Medi-Cal services that a preliminary criminal investigation has concluded.

(1) Notice of the commencement and conclusion of a preliminary criminal investigation pursuant to this section shall be made to the county behavioral health director or his or her equivalent.

(2) Communication between the department and a county specific to the commencement or conclusion of a preliminary criminal investigation pursuant to this section shall be deemed confidential and shall not be subject to any disclosure request, including, but not limited to, the Information Practices Act of ~~1997~~ *1977* (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the ~~Code of Civil Procedure),~~ *Civil Code),* the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), requests pursuant to a subpoena, or for any other public purpose, including, but not limited to, court testimony.

(3) Information shared by the department with a county regarding a preliminary criminal investigation shall be maintained in a manner to ensure protection of the confidentiality of the criminal investigation.

(4) The information provided to a county pursuant to this section shall only include the provider name, national provider identifier (NPI) number, address, and the notice that an investigation has commenced or concluded.

(5) A county shall not take any adverse action against a provider based solely upon the preliminary criminal investigation information disclosed to the county pursuant to this section.

(6) In the event of a preliminary criminal investigation of a county owned or operated program, the department has the option to, but is not required to, notify the county pursuant to this section when the department commences or concludes a preliminary criminal investigation.

(7) This section shall not limit the voluntary or otherwise legally mandated or contractually mandated sharing of information between the department and a county of information regarding audits and investigations of Drug Medi-Cal providers.

(8) "Commenced" means the time at which a complaint or allegation is assigned to an investigator for a field investigation.

(9) "Preliminary criminal investigation" means an investigation to gather information to determine if criminal law or statutes have been violated.

~~SEC. 34.~~

SEC. 66. Section 14251 of the Welfare and Institutions Code is amended to read:

14251. (a) (1) "Prepaid health plan" means a plan that meets all of the following criteria:

(A) Is licensed as a health care service plan by the Director of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section ~~1340),~~ *1340) of* Division ~~2,~~ *2 of the* Health and Safety Code), other than a plan organized and operating pursuant to Section 10810 of the Corporations Code that substantially indemnifies subscribers or enrollees for the cost of provided services, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal.

(B) Meets the requirements for participation in the Medicaid Program (Title XIX of the Social Security Act) on an at risk basis.

(C) Agrees with the State Department of Health Care Services to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

(2) "Prepaid health plan" includes any organization that is licensed as a plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and is subject to regulation by the Department of Managed Health Care pursuant to that act, and that contracts with the State Department of Health Care Services solely as a fiscal intermediary at risk.

(b) (1) Except for the requirement of licensure pursuant to the Knox-Keene ~~Act,~~ *Health Care Service Plan Act of 1975,* the State Director of Health Care Services may waive any provision of this chapter that the director determines is inappropriate for a fiscal intermediary at risk. An exemption or waiver shall be set forth in the fiscal intermediary ~~at risk~~ *at-risk* contract with the State Department of Health Care Services.

(2) "Fiscal intermediary at risk" means any entity that entered into a contract with the State Department of Health Care Services on a pilot basis pursuant to subdivision (f) of Section 14000, as in effect June 1, 1973, in accordance with which the entity received

capitated payments from the state and reimbursed providers of health care services on a fee-for-service or other basis for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk shall be at risk for the cost of administration and utilization of services or the cost of services, or both, for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk may share the risk with providers or reinsuring agencies or both. Eligibility of beneficiaries shall be determined by the State Department of Health Care Services and capitation payments shall be based on the number of beneficiaries so determined.

~~SEC. 35.~~

SEC. 67. Section 14499.71 of the Welfare and Institutions Code is amended to read:

14499.71. For the purposes of this article, "fiscal intermediary" means an entity that agrees to pay for covered services provided to Medi-Cal eligibles in exchange for a premium, subscription charge, or capitation payment; to assume an underwriting risk; and is licensed by the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 68. Section 14682.1 of the Welfare and Institutions Code is amended to read:

14682.1. (a) The State Department of Health Care Services shall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of, mental health plans for Medi-Cal beneficiaries.

(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the transition and continuing development of the Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan, as well as system transition and transformation issues pertaining to the delivery of mental health care services to Medi-Cal beneficiaries,

including services to children provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

(c) The committee shall consist of diverse representatives of concerned and involved communities, including, but not limited to, beneficiaries, their families, providers, mental health professionals, substance use disorder treatment professionals, statewide representatives of health care service plans, representatives of the California Mental Health Planning Council, public and private organizations, county ~~mental~~ *behavioral* health directors, and others as determined by the department. The department has the authority to structure this steering committee process in a manner that is conducive for addressing issues effectively, and for providing a transparent, collaborative, meaningful process to ensure a more diverse and representative approach to problem-solving and dissemination of information.

~~SEC. 36.~~

SEC. 69. Section 14707 of the Welfare and Institutions Code is amended to read:

14707. (a) In the case of federal audit exceptions, the department shall follow federal audit appeal processes unless the department, in consultation with the County Behavioral Health Directors Association of California, determines that those appeals are not cost beneficial.

(b) Whenever there is a final federal audit exception against the state resulting from expenditure of federal funds by individual counties, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The department shall provide evidence to the Controller that the county has been notified of the amount of the audit exception no less than 30 days before the offset is to occur. The department shall involve the appropriate counties in developing responses to any draft federal audit reports that directly impact the county.

~~SEC. 37.~~

SEC. 70. Section 14711 of the Welfare and Institutions Code is amended to read:

14711. (a) The department shall develop, in consultation with the County Behavioral Health Directors Association of California, a reimbursement methodology for use in the Medi-Cal claims processing and interim payment system that maximizes federal funding and utilizes, as much as practicable, federal Medicaid and Medicare reimbursement principles. The department shall work with the federal Centers for Medicare and Medicaid Services in the development of the methodology required by this section.

(b) Reimbursement amounts developed through the methodology required by this section shall be consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers.

(c) Administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers and shall be limited to 15 percent of the total actual cost of direct client services.

(d) The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative cost.

(e) The reimbursement methodology established pursuant to this section shall be based upon certified public expenditures, which encourage economy and efficiency in service delivery.

(f) The reimbursement amounts established for direct client services pursuant to this section shall be based on increments of time for all noninpatient services.

(g) The reimbursement methodology shall not be implemented until it has received any necessary federal approvals.

(h) This section shall become operative on July 1, 2012.

~~SEC. 38.~~

SEC. 71. Section 14717 of the Welfare and Institutions Code is amended to read:

14717. (a) In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside his or her county of original jurisdiction, the department shall take all of the following actions:

(1) On or before July 1, 2008, create all of the following items, in consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family

Policy ~~Institute,~~ *Institute of California,* the County Behavioral Health Directors Association of California, and the California Alliance of Child and Family Services:

(A) A standardized contract for the purchase of medically necessary specialty mental health services from organizational ~~providers,~~ *providers* when a contract is required.

(B) A standardized specialty mental health service authorization procedure.

(C) A standardized set of documentation standards and forms, including, but not limited to, forms for treatment plans, annual treatment plan updates, day treatment intensive and day treatment rehabilitative progress notes, and treatment authorization requests.

(2) On or before January 1, 2009, use the standardized items as described in paragraph (1) to provide medically necessary specialty mental health services to a foster child who is placed outside his or her county of original jurisdiction, so that organizational providers who are already certified by a mental health plan are not required to be additionally certified by the mental health plan in the county of original jurisdiction.

(3) (A) On or before January 1, 2009, use the standardized items described in paragraph (1) to provide medically necessary specialty mental health services to a foster child placed outside his or her county of original jurisdiction to constitute a complete contract, authorization procedure, and set of documentation standards and forms, so that no additional documents are required.

(B) Authorize a county mental health plan to be exempt from subparagraph (A) and have an addendum to a contract, authorization procedure, or set of documentation standards and forms, if the county mental health plan has an externally placed requirement, such as a requirement from a federal integrity agreement, that would affect one of these documents.

(4) Following consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family Policy ~~Institute,~~ *Institute of California,* the County Behavioral Health Directors Association of California, the California State Association of Counties, and the California Alliance of Child and Family Services, require the use of the standardized contracts, authorization procedures, and documentation standards and forms as specified in paragraph (1)

in the 2008–09 state-county mental health plan contract and each state-county mental health plan contract thereafter.

(5) The mental health plan shall complete a standardized contract, as provided in paragraph (1), if a contract is required, or another mechanism of payment if a contract is not required, with a provider or providers of the county's choice, to deliver approved specialty mental health services for a specified foster child, within 30 days of an approved treatment authorization request.

(b) The California Health and Human Services Agency shall coordinate the efforts of the department and the State Department of Social Services to do all of the following:

(1) Participate with the stakeholders in the activities described in this section.

(2) During budget hearings in 2008 and 2009, report to the Legislature regarding the implementation of this section and subdivision (c) of Section 14716.

(3) On or before July 1, 2008, establish the following, in consultation with stakeholders, including, but not limited to, the County Behavioral Health Directors Association of California, the California Alliance of Child and Family Services, and the County Welfare Directors Association of California:

(A) Informational materials that explain to foster care providers how to arrange for specialty mental health services on behalf of the beneficiary in their care.

(B) Informational materials that county child welfare agencies can access relevant to the provision of services to children in their care from the out-of-county local mental health plan that is responsible for providing those services, including, but not limited to, receiving a copy of the child's treatment plan within 60 days after requesting services.

(C) It is the intent of the Legislature to ensure that foster children who are adopted or placed permanently with relative guardians, and who move to a county outside their original county of residence, can access specialty mental health services in a timely manner. It is the intent of the Legislature to enact this section as a temporary means of ensuring access to these services, while the appropriate stakeholders pursue a long-term solution in the form of a change to the Medi-Cal Eligibility Data System that will allow these children to receive specialty mental health services through their new county of residence.

~~SEC. 39.~~

SEC. 72. Section 14718 of the Welfare and Institutions Code is amended to read:

14718. (a) This section shall be limited to specialty mental health services reimbursed to a mental health plan that certifies public expenditures subject to cost settlement or specialty mental health services reimbursed through the department's fiscal intermediary.

(b) The following provisions shall apply to matters related to specialty mental health services provided under the approved Medi-Cal state plan and the Specialty Mental Health Services Waiver, including, but not limited to, reimbursement and claiming procedures, reviews and oversight, and appeal processes for mental health plans (MHPs) and MHP subcontractors.

(1) As determined by the department, the MHP shall submit claims for reimbursement to the Medi-Cal program for eligible services.

(2) The department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the MHP. The department may offset the amount of any state disallowance, or audit exception or overpayment against subsequent claims from the mental health plan, through the 2010–11 fiscal year. This offset may be done at any time, after the department has invoiced or otherwise notified the mental health plan about the audit exception, disallowance, or overpayment. The department shall determine the amount that may be withheld from each payment to the mental health plan. The maximum withheld amount shall be 25 percent of each payment as long as the department is able to comply with the federal requirements for repayment of federal financial participation pursuant to Section 1903(d)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396b(d)(2)). The department may increase the maximum amount when necessary for compliance with federal laws and regulations.

(3) (A) Oversight by the department of the MHPs may include client record reviews of Early *and* Periodic ~~Screening Diagnosis~~ *Screening, Diagnosis,* and Treatment (EPSDT) specialty mental health services rendered by MHPs and MHP subcontractors under the Medi-Cal specialty mental health services waiver in addition to other audits or reviews that are conducted.

(B) The department may contract with an independent, nongovernmental entity to conduct client record reviews. The contract awarded in connection with this section shall be on a competitive bid basis, pursuant to the Department of General Services contracting requirements, and shall meet both of the following additional requirements:

(i) Require the entity awarded the contract to comply with all federal and state privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and Section 1798.81.5 of the Civil Code. The entity shall be subject to existing penalties for violation of these laws.

(ii) Prohibit the entity awarded the contract from using or disclosing client records or client information for a purpose other than the one for which the record was given.

(iii) Prohibit the entity awarded the contract from selling client records or client information.

(C) For purposes of this paragraph, the following terms shall have the following meanings:

(i) "Client record" means a medical record, chart, or similar file, as well as other documents containing information regarding an individual recipient of services, including, but not limited to, clinical information, dates and times of services, and other information relevant to the individual and services provided and that evidences compliance with legal requirements for Medi-Cal reimbursement.

(ii) "Client record review" means examination of the client record for a selected individual recipient for the purpose of confirming the existence of documents that verify compliance with legal requirements for claims submitted for Medi-Cal reimbursement.

(D) The department shall recover overpayments of federal financial participation from MHPs within the timeframes required by federal law and regulation for repayment to the federal Centers for Medicare and Medicaid Services.

(4) (A) The department, in consultation with mental health stakeholders, the County Behavioral Health Directors Association of California, and MHP subcontractor representatives, shall provide

an appeals process that specifies a progressive process for resolution of disputes about claims or recoupments relating to specialty mental health services under the Medi-Cal specialty mental health services waiver.

(B) The department shall provide MHPs and MHP subcontractors the opportunity to directly appeal findings in accordance with procedures that are similar to those described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, until new regulations for a progressive appeals process are promulgated. When an MHP subcontractor initiates an appeal, it shall give notice to the MHP. The department shall propose a rulemaking package consistent with the department's appeals process that is in effect on July 1, ~~2012~~ *2012,* by no later than the end of the 2013–14 fiscal year. The reference in this subparagraph to the procedures described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, shall only apply to those appeals addressed in this subparagraph.

(C) The department shall develop regulations as necessary to implement this paragraph.

(5) The department shall conduct oversight of utilization controls as specified in Section 14133. The MHP shall include a requirement in any subcontracts that all inpatient subcontractors maintain necessary licensing and certification. MHPs shall require that services delivered by licensed staff are within their scope of practice. Nothing in this chapter shall prohibit the MHPs from establishing standards that are in addition to the federal and state requirements, provided that these standards do not violate federal and state requirements and guidelines.

(6) (A) Subject to federal approval and consistent with state requirements, the MHP may negotiate rates with providers of specialty mental health services.

(B) Any excess in the distribution of funds over the expenditures for services by the mental health plan shall be spent for the provision of specialty mental health services and related administrative costs.

(7) Nothing in this chapter shall limit the MHP from being reimbursed appropriate federal financial participation for any qualified services. To receive federal financial participation, the

mental health plan shall certify its public expenditures for specialty mental health services to the department.

(8) Notwithstanding Section 14115, claims for federal reimbursement for service pursuant to this chapter shall be submitted by MHPs within the timeframes required by federal Medicaid requirements and the approved Medicaid state plan and waivers.

(9) The MHP shall use the fiscal intermediary of the Medi-Cal program of the State Department of Health Care Services for the processing of claims for inpatient psychiatric hospital services rendered in fee-for-service Medi-Cal hospitals. The department shall request the Controller to offset the distribution of funds to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, or the Vehicle License Collection Account of the Local Revenue Fund, or funds from the Mental Health Account or the Behavioral Health Subaccount of the Local Revenue Fund 2011 for the nonfederal financial participation share for these claims.

(c) Counties may set aside funds for self-insurance, audit settlement, and statewide program risk pools. The counties shall assume all responsibility and liability for appropriate administration of the funds. Special consideration may be given to small counties with a population of less than 200,000. ~~Nothing in the paragraph shall in any way~~ *This subdivision shall not* make the state or department liable for mismanagement or loss of funds by the entity designated by counties under this subdivision.

(d) The department shall consult with the ~~California Mental Health Directors Association~~ *County Behavioral Health Directors Association of California* in February and September of each year to obtain data and methodology necessary to forecast future fiscal trends in the provision of specialty mental health services provided under the Medi-Cal specialty mental health services waiver, to estimate yearly specialty mental health services related costs, and to estimate the annual amount of federal funding participation to reimburse costs of specialty mental health services provided under the Medi-Cal specialty mental health services waiver. This shall include a separate presentation of the data and methodology necessary to forecast future fiscal trends in the provision of Early Periodic Screening, Diagnosis, and Treatment specialty mental health services provided under the Medi-Cal specialty mental

health services waiver, to estimate annual EPSDT specialty mental health services related costs, and to estimate the annual amount of EPSDT specialty mental health services provided under the state Medi-Cal specialty mental health services waiver, including federal funding participation to reimburse costs of EPSDT.

(e) When seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Medi-Cal specialty mental health services, the department shall consult with staff of the Legislature, counties, providers, and other stakeholders in the development of the state plan amendment or waiver.

(f) This section shall become operative on July 1, 2012.

~~SEC. 40.~~

SEC. 73. Section 14725 of the Welfare and Institutions Code is amended to read:

14725. (a) The State Department of Health Care Services shall develop a quality assurance program to govern the delivery of Medi-Cal specialty mental health services, in order to ~~assure~~ *ensure* quality patient care based on community standards of practice.

(b) The department shall issue standards and guidelines for local quality assurance activities. These standards and guidelines shall be reviewed and revised in consultation with the County Behavioral Health Directors Association of California, as well as other stakeholders from the mental health community, including, but not limited to, individuals who receive services, family members, providers, mental health advocacy groups, and other interested parties. The standards and guidelines shall be based on federal Medicaid requirements.

(c) The standards and guidelines developed by the department shall reflect the special problems that small rural counties have in undertaking comprehensive quality assurance systems.

~~SEC. 41.~~

SEC. 74. Section 15204.8 of the Welfare and Institutions Code is amended to read:

15204.8. (a) The Legislature may appropriate annually in the Budget Act funds to support services provided pursuant to Sections 11325.7 and 11325.8.

(b) Funds appropriated pursuant to subdivision (a) shall be allocated to the counties separately and shall be available for expenditure by the counties for services provided during the budget year. A county may move funds between the two accounts during

the budget year for expenditure if necessary to meet the particular circumstances in the county. Any unexpended funds may be retained by each county for expenditure for the same purposes during the succeeding fiscal year. By November 20, 1998, each county shall report to the department on the use of these funds.

(c) Beginning January 10, 1999, the Department of Finance shall report annually to the Legislature on the extent to which funds available under subdivision (a) have not been spent and may reallocate the unexpended balances so as to better meet the need for services.

(d) No later than September 1, 2001, the department in consultation with relevant stakeholders, which may include the County Welfare Directors Association and the County Behavioral Health Directors Association of California, shall develop the allocation methodology for these funds, including the specific components to be considered in allocating the funds.

~~SEC. 42.~~

SEC. 75. Section 15847.7 of the Welfare and Institutions Code is amended to read:

15847.7. (a) For purposes of Sections 15847, 15847.3, and 15847.5, "group health coverage" includes any health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

(b) This section shall become operative on July 1, 2014.

~~SEC. 43. Section 17604 of the Welfare and Institutions Code is amended to read:~~

~~17604. (a) All motor vehicle license fee revenues collected in the 1991–92 fiscal year that are deposited to the credit of the Local Revenue Fund shall be credited to the Vehicle License Fee Account of that fund.~~

~~(b) (1) For the 1992–93 fiscal year and fiscal years thereafter, from vehicle license fee proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Vehicle License Fee Account of the Local Revenue Fund until the deposits equal the amounts that were allocated to counties, cities, and cities and counties as general purpose revenues in the prior fiscal year pursuant to this chapter from the Vehicle License Fee Account in the Local Revenue Fund and the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the Local Revenue Fund.~~

~~(2) Any excess vehicle fee revenues deposited into the Local Revenue Fund pursuant to Section 11001.5 of the Revenue and Taxation Code shall be deposited in the Vehicle License Fee Growth Account of the Local Revenue Fund.~~

~~(3) The Controller shall calculate the difference between the total amount of vehicle license fee proceeds deposited to the credit of the Local Revenue Fund, pursuant to paragraph (1) of subdivision (a) of Section 11001.5 of the Revenue and Taxation Code, and deposited into the Vehicle License Fee Account for the period of July 16, 2009, to July 15, 2010, inclusive, and the amount deposited for the period of July 16, 2010, to July 15, 2011, inclusive.~~

~~(4) Of vehicle license fee proceeds deposited to the Vehicle License Fee Account after July 15, 2011, an amount equal to the difference calculated in paragraph (3) shall be deemed to have been deposited during the period of July 16, 2010, to July 15, 2011, inclusive, and allocated to cities, counties, and a city and county as if those proceeds had been received during the 2010–11 fiscal year.~~

~~(c) (1) On or before the 27th day of each month, the Controller shall allocate to each county, city, or city and county, as general purpose revenues the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Vehicle License Fee Account of the Local Revenue Fund, in accordance with paragraphs (2) and (3).~~

~~(2) For the 1991–92 fiscal year, allocations shall be made in accordance with the following schedule:~~

~~Jurisdiction~~	~~Allocation Percentage~~
~~Alameda~~	~~4.5046~~
~~Alpine~~	~~0.0137~~
~~Amador~~	~~0.1512~~
~~Butte~~	~~0.8131~~
~~Calaveras~~	~~0.1367~~
~~Colusa~~	~~0.1195~~
~~Contra Costa~~	~~2.2386~~
~~Del Norte~~	~~0.1340~~
~~El Dorado~~	~~0.5228~~
~~Fresno~~	~~2.3531~~

~~Glenn~~	~~0.1391~~
~~Humboldt~~	~~0.8929~~
~~Imperial~~	~~0.8237~~
~~Inyo~~	~~0.1869~~
~~Kern~~	~~1.6362~~
~~Kings~~	~~0.4084~~
~~Lake~~	~~0.1752~~
~~Lassen~~	~~0.1525~~
~~Los Angeles~~	~~37.2606~~
~~Madera~~	~~0.3656~~
~~Marin~~	~~1.0785~~
~~Mariposa~~	~~0.0815~~
~~Mendocino~~	~~0.2586~~
~~Merced~~	~~0.4094~~
~~Modoc~~	~~0.0923~~
~~Mono~~	~~0.1342~~
~~Monterey~~	~~0.8975~~
~~Napa~~	~~0.4466~~
~~Nevada~~	~~0.2734~~
~~Orange~~	~~5.4304~~
~~Placer~~	~~0.2806~~
~~Plumas~~	~~0.1145~~
~~Riverside~~	~~2.7867~~
~~Sacramento~~	~~2.7497~~
~~San Benito~~	~~0.1701~~
~~San Bernardino~~	~~2.4709~~
~~San Diego~~	~~4.7771~~
~~San Francisco~~	~~7.1450~~
~~San Joaquin~~	~~1.0810~~
~~San Luis Obispo~~	~~0.4811~~
~~San Mateo~~	~~1.5937~~
~~Santa Barbara~~	~~0.9418~~
~~Santa Clara~~	~~3.6238~~
~~Santa Cruz~~	~~0.6714~~
~~Shasta~~	~~0.6732~~
~~Sierra~~	~~0.0340~~
~~Siskiyou~~	~~0.2246~~
~~Solano~~	~~0.9377~~
~~Sonoma~~	~~1.6687~~
~~Stanislaus~~	~~1.0509~~

Sutter	0.4460
Tehama	0.2986
Trinity	0.1388
Tulare	0.7485
Tuolumne	0.2357
Ventura	1.3658
Yolo	0.3522
Yuba	0.3076
Berkeley	0.0692
Long Beach	0.2918
Pasadena	0.1385

(3) For the 1992–93, 1993–94, and 1994–95 fiscal years and fiscal years thereafter, allocations shall be made in the same amounts as were distributed from the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the prior fiscal year.

(4) For the 1995–96 fiscal year, allocations shall be made in the same amounts as distributed in the 1994–95 fiscal year from the Vehicle License Fee Account and the Vehicle License Fee Growth Account after adjusting the allocation amounts by the amounts specified for the following counties:

Alpine	$(11,296)
Amador	25,417
Calaveras	49,892
Del Norte	39,537
Glenn	(12,238)
Lassen	17,886
Mariposa	(6,950)
Modoc	(29,182)
Mono	(6,950)
San Benito	20,710
Sierra	(39,537)
Trinity	(48,009)

(5) (A) For the 1996–97 fiscal year and fiscal years thereafter, allocations shall be made in the same amounts as were distributed from the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the prior fiscal year.

~~(B) Initial proceeds deposited in the Vehicle License Fee Account in the 2003–04 fiscal year in the amount that would otherwise have been transferred pursuant to former Section 10754 of the Revenue and Taxation Code for the period June 20, 2003, to July 15, 2003, inclusive, shall be deemed to have been deposited during the period June 16, 2003, to July 15, 2003, inclusive, and allocated to cities, counties, and a city and county during the 2002–03 fiscal year.~~

~~(d) The Controller shall make monthly allocations from the amount deposited in the Vehicle License Collection Account of the Local Revenue Fund to each county in accordance with a schedule to be developed by the State Department of State Hospitals in consultation with the County Behavioral Health Directors Association of California, which is compatible with the intent of the Legislature expressed in the act adding this subdivision.~~

~~(e) Before making the monthly allocations in accordance with paragraph (5) of subdivision (c) and subdivision (d), and pursuant to a schedule provided by the Department of Finance, the Controller shall adjust the monthly distributions from the Vehicle License Fee Account to reflect an equal exchange of sales and use tax funds from the Social Services Subaccount to the Health Subaccount, as required by subdivisions (d) and (e) of Section 17600.15, and of Vehicle License Fee funds from the Health Account to the Social Services Account. Adjustments made to the Vehicle License Fee distributions pursuant to this subdivision shall not be used in calculating future year allocations to the Vehicle License Fee Account.~~

SEC. 76. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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